

Reutilization of Durable Medical Equipment in State Medicaid Populations

Iowa Program for Assistive Technology



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Abstract

Over the Summer and Fall of 2015 I completed a practicum for the Iowa Program for Assistive Technology where I investigated the feasibility of a program that tracks and picks up Durable Medical Equipment (wheelchairs, walkers, hospital beds, etc.) no longer used by a state's Medicaid population. These devices would then be refurbished and given as an option to other Medicaid members. This equipment typically ends up in landfills and could save a state's Medicaid program millions of dollars through reuse. Currently this cost saving measure is only being enacted in Kansas, Oklahoma and soon to be South Dakota, while a number of states are considering implementation. I completed a state by state analysis of Medicaid policies looking for barriers and opportunities to implementation of such a program in Iowa. The results of which were used to draft a response to a potential Request for Proposal from the state. In addition to the proposal, a business plan, tracking database and website were created that could be used by the program.

Introduction

According to the CDC's National Center for Health Statistics, total health expenditures for our nation are at \$2.9 trillion, with \$43 Billion of that money going towards Durable Medical Equipment (CDC, 2013). While our nation struggles with reducing costs, increasing access and ensuring quality care there are programs like the Iowa Program for Assistive Technology that has proven techniques to improve on all three values of the Triple Aim. Assistive technology (AT) is adapted equipment used by individuals with disabilities in order to perform functions that might otherwise be difficult or impossible. AT can be complex like a hearing aid, home control system or power

wheelchair but it can also be simple like a magnifying glass, ramp or cane (CTD, 2012). A subsection of AT is Durable Medical Equipment or DME. We got the term DME from the Center for Medicare and Medicaid Services (CMS). CMS defines DME as “medical equipment that is; long lasting (durable), has a medical reason for use, not used by someone that does not have a medical reason and is designed for home use.” All U.S. state and territory Medicaid programs pay for DME to some extent. According to CMS, accessing DME is the fifth most used Medicaid service with 23% of members utilizing some form of durable medical equipment (KFF, 2012). DME includes such items as Wheelchairs, Hospital Beds, CPAP machines, bath chairs and augmentative communication devices. What these devices all have in common is that they enable independence for people with disabilities and health conditions. This independence that these devices give allow people to remain in their home out of the more costly hospitals and nursing homes.

The use of DME is a key characteristic of public health’s purpose to avoid further complications in those with health conditions. The utilization of these devices that allow for independence is so important that in 1988 our nation passed the Technology Related Assistance for Individuals with Disabilities Act or Tech Act. Originally authored by Iowa’s Senator Tom Harkin, the Tech Act set up and funds a program in each state and territory whose sole mission is to remove barriers of access to assistive technology to its residents. One of the ways that states were able to meet this demand is through the development of equipment exchange and recycling programs which become popular in the 90’s and early 2000’s (NATAP, 2000). These programs give assistive technology and DME a second life, making the device more financially available. The Iowa Program for Assistive Technology (Iowa’s Tech Act

entity) has both of these; a program that allows for exchange and a program that refurbishes equipment. The Used Equipment Referral Services or UERS is an online listing service that enables lowans free access to buy, sell and donate AT. This program is currently contracted to Iowa COMPASS, the state's disability information and referral service. In refurbishing activities, IPAT contracts with Easter Seals Iowa located in Des Moines. Easter Seals takes in donated equipment, refurbishes and loans it out to lowans from all around the state. Yet, these programs still have their limitations as there is no formal arrangement to ensure posting on UERS or donating to Easter Seals. To ensure a supply of equipment Kansas was the first Tech Act that contracted with their state Medicaid program. The purpose of the practicum was to research the feasibility of bringing such a program to Iowa.

Discussion

While pursuing my master's degree at the college I also maintained part-time employment at Iowa COMPASS. As the director of the UERS program for the past five years I've been keenly aware of the needs for access to assistive technology for lowans. One problem that I had identified was that there was a massive amount of DME that was not being used. I would be contacted daily with requests from lowans wanting to know what to do with the equipment that they're family member no longer needs. Sadly, that need often comes when the family member passes away. But also this can come from changes in disability status. These changes come from both ends of the spectrum of disability from people no longer needing the equipment or needing a more complex piece of equipment as their condition either improves or worsens. Along with these changes many lowans do not know what to do with this equipment after they no

longer need it. I had heard many stories of people just throwing the equipment away or trying to pawn them. With so many people with disabilities using DME there remain only a small percentage of those that actually know what to do with the equipment after they no longer need it. This problem of seeing DME on curbsides, flea markets and dumps is what initially drove the Kansas legislature in 1999 to look in to developing an inventory tracking program for their Medicaid program. To tackle this problem they worked with Kansas' Tech Act program director, Dr. Sara Sack to develop such a program. Dr. Sack received a field-initiative grant from the National Institute on Disability Rehabilitation and Research (NIDRR) to develop a pilot program. Through the NIDRR funding the Kansas Tech Act (Assistive Technology for Kansans or ATK), which is coordinated by the University of Kansas, worked closely with Kansas Medicaid to develop the Kansas Equipment Exchange (KEE) in 2003. After the pilot study was completed the state Medicaid program funds the KEE which include ATK but also a network of vendors and contractors to track, transport and refurbish durable medical equipment purchased with Medicaid money. Because of this effort, Dr. Sack estimates that the Medicaid program has saved over \$4 million dollars relying on refurbished equipment instead of buying new.

I wanted to see what it would take to recreate what was going on in Kansas with what we have in Iowa. I connected with IPAT director Jane Gay to act as my preceptor to turn this work in to a practicum. The results of which would not only give me valuable system change and program development experience but also would give IPAT the tools needed to develop the Medicaid partnership in Iowa.

In working closely with Jane Gay we developed a game plan to research a Medicaid-funded DME refurbishment system. I proposed completing a state by state

Medicaid policy analysis that would look at each program and identify strengths and weaknesses of implementing a program, like the one in Kansas, in that state. In the progression of the practicum over the two semester this changed significantly. But, before beginning the policy analysis I wanted to know more about the Kansas program. I connected with Dr. Sack and traveled the Parsons State Hospital and Training Center in Parsons, Kansas where ATK is based. There I interviewed Dr. Sack and Sheila Simmons, the coordinator for ATK. Through the interview process I was able to discover what had worked and what had not in developing the program. I also learned that Oklahoma had recently developed such a partnership with their Medicaid program and that South Dakota was in the process as well. I used this information not only to influence my business model and RFP response but also as a template for policy analysis in the other states.

After that interview, I returned to begin Medicaid policy analysis for each state. This quickly proved to be a gargantuan task that left me very frustrated largely because of the disparate availability of information on a state's Medicaid program. I needed to know intricate details about the program and thought that this information would be readily available online like it is in Iowa. Sadly, state after state I would research would not have their administrative policies available online or would be so truncated as to not prove useful for my research. Next, I attempted to connect directly with the state's Medicaid office. In another example of in-state naiveté I was met with many unreturned messages, emails and requests of no contact (New Jersey). I would later identify that New Jersey was actually the first state to have a Medicaid DME refurbishment program in the mid-90's but ended disastrously when a member died from a faulty wheelchair that had been refurbished improperly. Because of the

vendors and consumer advocates demanded its end only a year after the program began. I had a long experience working closely with contacts in Iowa Medicaid Enterprises through my work and assumed that this would be true in other states. While I was able to find great information directly through CMS and the Kaiser Family Foundation it was not to the level of detail I was looking for to accurately identify the opportunities and barriers for each state. So instead, working with my preceptor, I switched views and began looking at state's where Medicaid Refurbishment was either considered or was being developed. I was able to do this through connecting with each state's Tech Act director which were all very open to being interviewed. I think that it helped that not only did I work for IPAT but I was doing this practicum for IPAT. Over the summer and early Fall I interviewed 23 state Tech Act directors which gave me valuable information on the qualities that needed to exist to produce a successful Medicaid refurbishment program.

During that process I discovered that the Pass It On Center was also participating in this research and planned to present their findings at the National Reuse Conference held in Washington D.C. in late August. The Pass It On Center is a national program authorized by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) to meet the research and educational demands for all the Tech Act entities. I had already finished most of my research when I connected by phone and email with Trish Redmon, Joy Kniskern and Carolyn Phillips of the Pass It On Center. I had a great ongoing conversation with all three as we talked about what state's had tried and what was being considered. While their research primarily focused on Kansas and Oklahoma, mine was focused on the interviews with

the state Tech Act directors. While I'm not certain those conversations actually influenced their final paper I am including it in [Appendix II](#) as a result of my practicum.

My summer consisted largely of the Tech Act director interviews which enable me to begin the development of the business plan and response to a potential RFP. Originally I had planned on just doing a business plan but as I was going through the interviewing process I discovered that how the partnership developed was far more important than what the partnership would actually result in. Additionally, I found that both Kansas and Oklahoma and soon to be South Dakota legislatures all released the same Request for Proposal form. Assuming that if such a program were to start in Iowa it would use a similar RFP, I created an advanced response for IPAT. This part was relatively easy as I knew the landscape of providers, vendors and Medicaid very well in Iowa. Through that process I had ongoing conversations with Sabrina Johnson, the DME expert at IME, who was very interested in implementation. Ultimately her focus changed to that of Medicaid Modernization through the introduction of private managed care organizations in Iowa. And while it may not be of interest to IME in the foreseeable future it is something that IPAT plans to present to the four MCO's as they research ways to reduce costs of the Medicaid program in Iowa.

While the Pass It On Center Report gives a great summarization of my policy research and the business plan/RFP response shows what it would take to create it there remains the unanswered question on how such a program starts in the legislature. The first thing that needs to happen is that the state must retain ownership of the DME throughout its life. The vast majority of states Medicaid rules state that the consumer owns the equipment. This was largely put in place to avoid the state needing to dispose of the equipment and avoid many legal issues. Changing this rule allows the

state the ability to mandate the equipment for refurbishment. Through my interviews, no state had actually had to force a member to give up the equipment after they no longer needed it and found that many members and their families and service providers were happy to see it being refurbished. Once you have changed the Medicaid rules you then need to have a series of stakeholder meetings with all potentially involved in the payment, sale and use of DME. Linda Jaco, Director of the Oklahoma Tech Act, stated that this was the longest part of the entire process but ensured that there was complete buy-in to the program. In state's that had considered Medicaid refurbishment these stakeholder meetings were often where the initiative died, not even making it to the legislative process. A majority of these states identified vendor backlash as the primary reason why these conversations stopped. Many vendors felt that using refurbished equipment was sub-par and unsanitary a sentiment that many consumer advocate groups echoed. Through these ongoing conversations, often lasting over many years, states are able to overcome these hesitations and vendors often find that participating in a reuse program brings in consumer loyalty as well as an alternative funding source by billing Medicaid for the refurbishment costs. For my proposal to work these two things would need to happen in Iowa.

My last objective in the practicum was development of the tracking database and website for the proposed Medicaid refurbishment program. This tracking portal would be accessible by Medicaid care managers and members, DME vendors and IPAT staff. The tracking system begins when a new piece of DME is purchased by Medicaid. The vendor places a sticker on the piece of equipment with a tracking number that is entered in to the database through an online portal. Then the vendor gives the equipment to the Medicaid member. After four weeks of retaining the equipment an

IPAT staff contacts the member via phone. This conversation is used to ascertain if they are still using the equipment possibly evaluating for further training or fitting in using the device. If the member states that they no longer use or need the equipment IPAT staff requests that the member return their equipment for refurbishment. This can either be done through arranging pick up from IPAT staff or a participating DME vendor or by the member transporting the equipment themselves. When the DME changes location the IPAT staff updates the listing in the database to identify the current location status of the equipment. After IPAT staff refurbish the equipment they update the website saying it's ready for disbursement. This status allows care managers and vendors to identify available refurbished DME. When a Medicaid member needs any piece of DME they arrive at a vendor with a prescription from their doctor. The vendor then checks the tracking database to see if there is a refurbished piece of DME that would meet their needs. If there is and if the member agrees to receive refurbished equipment then the vendor contacts the site where the equipment is and arrangements are made to transport the equipment to the member or have the member pick up.

While pursuing my master's in public health in health policy I am also working on completing a certificate in Health Informatics at the University. This graduate college certificate involves education on the programming languages and systems involved in the information technology systems used by health care. Specifically, this training gave me the skills needed to develop a Microsoft Access Database and a Microsoft SharePoint website. This development took a considerable amount of my time in the fall not only in implementation but, in the beginning, just figuring out which software to use to create what I was looking for. I had originally planned on using

MySQL, a database language that I was familiar with. I had also planned on using Adobe Dreamweaver to create the portal and enrolled in an edX course to learn this particular piece of software. After finishing and creating my first Dreamweaver website I then created the database first using MySQL. MySQL is a very powerful database program but getting it to do what I wanted it to do was quickly going over my expertise level. With guidance from my informatics professors I settled on building the database with Microsoft Access. This was a fair easier undertaking than building it with MySQL would have been. Unfortunately, there was no longer a way to connect my MS Access database to my Dreamweaver page as Adobe had discontinued support of MS Access years ago. At that point, again with the help of my instructors, Drs. Nadkarni and Phillips, I uploaded the database to a website I created using the Microsoft SharePoint web development software. This website is not available to the public as the website hosting offered UI students does not support database use and the SharePoint pages are only available on UIHC computers which I was given access to via IPAT.

Personal Assessment

I believe the majority of this practicum consisted of trying to find the best solutions to the issue that needed solved. I found this practice to be both frustrating and extremely rewarding. When completing many aspects of public health research and services we are given a set formula or tool and instructions on how to use it. In researching a new policy alternative and mapping out how it might work you don't have the luxury of following a set path. This is why instead of doing the research on my own I relied on a network of experts through the Tech Act entities. This approach was new to me

because it wasn't simply collaboration it was actively asking for assistance, something I had not done in my career for a very long time.

This approach is firmly set in the public health competencies in the Social and Behavioral Sciences discipline in [E. 3.], *Identify individual, organizational and community concerns, assets, resources and deficits for social and behavioral factors that affect health of individuals and populations* and in the Health Policy and Management discipline in [D. 9.] *Communicate health policy and management issues using appropriate channels and technologies*. Both of these competencies are focused on communication. I needed to communicate with experts not only within the service field in my conversations with the Tech Act directors but I also needed experts to help me identify technological and program capacity options. I relied heavily on my informatics professors for that technological capacity. In regards to the program capacity my work necessitated connecting with a large network of potential stakeholders in the Medicaid Reuse program in Iowa. Those conversations with my preceptor, DME vendors, Iowa Medicaid Employees and contracted service providers had a large influence in the development of my business plan and RFP response. Those were tough conversations logistically as I struggled with what position I was coming from. Was I a student that was simply doing some investigative research for the program or was I an employee of IPAT that was going to really create the program? I constantly wavered between the two approaches during interviews. This switching of hats was primarily reactive to the interests of the person being interviewed. For example, in interviewing Matt Flatt, a representative of the Midwest Association for Medical Equipment Services (MAMES) I very strongly communicated my intent in doing investigative research. This approach tended to disarm many vendors and providers as

well as contributed to lengthy conversations with Iowa Medicaid employees. In contrast, when speaking with the Tech Act directors and the Pass It On Center putting forth my own job title and career experience afforded me a common ground that we could communicate. I believe being able to rely on this industry comradery allowed me to gather intricate details from my interviews that would not have been afforded me if I were only researching.

While the majority of my time in the practicum focused on communication seen in [E. 3.] and [D. 9.] the remaining discipline specific public health competencies were firmly rooted within the entire Health Policy and Management domain. In fact, there is nor a single competency in that discipline which I do not touch upon in the practicum.

| HPM Competency | Practicum Activity |
|--|---|
| 1. Identify the main components and issues of the organization, financing and delivery of health service and public health systems in the U.S. | Interacting with the network of Tech Act entities in the US. Interviews with vendors and service providers. |
| 2. Describe the legal and ethical bases for public health and health services. | Connecting with AT protection and advocacy legal projects in the identification of DME liability for refurbishment |
| 3. Explain methods of ensuring community health safety and preparedness. | Identifying strengths of refurbishment to respond to disasters |
| 4. Discuss the policy process for improving the health status of populations. | The pitch to vendors and providers consisted of the return on investment of the use of DME to avoid institutional placement |
| 5. Apply the principles of program planning, development, budgeting, management and evaluation in organizational and community initiatives. | Development of the business plan and RFP response |
| 6. Apply principles of strategic planning and marketing to public health. | Development of the business plan and RFP response |
| 7. Apply quality and performance improvement concepts to address organizational performance issues. | Development of the business plan and RFP response |
| 8. Apply "systems thinking" for resolving organizational problems. | Development of the business plan and RFP response as well as the interview process |

| | |
|---|--|
| | in assuage fears of development using historical data on program effectiveness |
| 9. Communicate health policy and management issues using appropriate channels and technologies. | Used primarily in the interview processes and detailed in the section on communication |
| 10. Demonstrate leadership skills for building partnerships. | Used primarily in the interview processes |

Outside of the discipline specific realms I concentrated a large amount of my work on Communication/Informatics, Professionalism, Program Planning and Systems Thinking. *Communication and Informatics* were a very integral part of my work on the practicum. My approach to the problem focused on a solution that was based on utilization of assistive technology. I used such tools not only in the more obvious development of the database and website but I also used a system in OneNote to track the multitude of conversations that I was having through in-person, email and phone interviews. Having a format for questions as well as a set of reminders in place through integration with Outlook I was able to easily access past interviews as well as continue follow-up on conversations that were not being returned. These interviews drew heavily from the *Professionalism* cross-competency discipline. More obvious professional considerations include dress, communication formatting and how to address the interviewer with respect. But a very important part of professionalism is a good understanding of where the person you are interacting with is coming from. The ability to communicate empathy and understanding of the stakeholder's position allowed me a greater level of detail in my research. These details were then used within the cross-competency discipline of *Program Planning*. This involved ongoing conversations with my preceptor and providers but also introspective thinking based on my own experience on what successful program implementation looks like. This

also involved development a budget for the program which was not something I had a lot of experience in with my degree or really too much within my work experience. Most of the budgetary considerations were done by specialists or were not an area of concentration of any of my classes. Outwardly, the majority of my practicum's work in *Systems Thinking* is only seen in my poster. While research in to Medicaid policy, state budgets and program demands were a large focus of the work the actual product of that work is relatively small. So while I may have spent months looking at state Medicaid budgets and the expenses of running a refurbishment program those only resulted in one entry on a proposed budget. The same can be said about programmatic and policy development for the proposed program. This system thinking allowed me the knowledge to effectively pitch the idea that could save Iowa millions in DME related expenses.

Conclusions and Recommendations

My next step in the development of a Medicaid-funded DME refurbishment program involves moving the work from the theoretical in to actual production. During the work of the practicum the landscape of Iowa Medicaid services has drastically changed. In the early spring of 2014, IPAT was having conversations with Iowa Medicaid that indicated they were interested in starting the conversation to make refurbishment a reality for their members. At that time the concept of switching to private managed care organization performing the administrative duties for Iowa Medicaid was not fully realized. By mid-summer it was evident through several discussions that, while IME was interested in the concept, had no ability to bring the program in to fruition through their traditional administrative means. Since the administrative duties are now being

abdicated to the MCO's they would be the logical entities where the practicum would be pitched. That conversation has gotten extremely complicated. First, at the writing of this report, the state has yet to receive federal approval to move the majority of their Medicaid members in to private managed care organizations. While we hope to see that decision the first week of November many consumer advocates and democratic legislators are trying to slow down or in many cases avoid privatization all together. The main complaint is that the \$4 billion Iowa Medicaid system is just too complex and the MCO's as well as the members and providers are just not ready. However that discussion lies, from my perspective I believe at most we'll see privatization delayed until June of 2016 but it is more likely that CMS will allow Iowa to go forward as planned for January 1st, 2016 rollout date.

To get the MCO's interested in DME refurbishment as a potential cost saving tool involves a fair amount of bureaucracy if IPAT is the source of this innovation. To even pitch an idea to the MCO's IPAT must get approval from the University of Iowa Hospitals and a lot of those conversations have already taken place. The sheer amount of providers clamoring for contracts with the MCO's is quite impressive. Unfortunately, while refurbishing DME purchased by Medicaid is a great concept there remains two fundamental flaws with the program.

The first is that it takes a very long time to set up and then even longer to actually see a return on investment. Kansas saw the least number of years in a four year turnaround from legislative inception to actual program funding. They were also innovators of the program, had a grant from NIDRR and had a very strong legislature that wanted to see the program developed. In contrast it took Oklahoma thirteen years to go from concept to program and South Dakota is looking about the same. And

while Oklahoma is somewhat in its infancy (started in 2012) and South Dakota's RFP responses were due in early November 2015 I would expect a similar roll out in other states. In fact, that's the predominantly common response from the twenty-one other states. They had all been involved with some level of stakeholder conversations but nearly all either ceased or temporarily halted conversations due to the tumultuous environment in their Medicaid programs after the new regulations afforded them through the Affordable Care Act. While Virginia and Vermont have gotten a little farther than the other nineteen states by instituting a sticker program requesting the DME be returned for refurbishment their state Medicaid programs have yet to fund actually refurbishment activities like that seen in Kansas. While it's hard to show whether refurbishment is something that is more popular in states that did not expand Medicaid the three that have a refurbishment program (Kansas, Oklahoma and, soon to be, South Dakota) were all states that did not expand Medicaid. One could hypothesize that by not expanding Medicaid this allowed their administrative agencies the time and personnel resources to focus on cost saving measures like refurbishment. While the verbal consensus from states that were considering a refurbishment but could not because of expansion (13 of the 21 states considering refurbishment had also expanded Medicaid) it's important to see that all three states were well into refurbishment when the ACA was implemented.

Secondly, it takes time to see big numbers in equipment being returned since the system does not track already purchased equipment. The numbers seen in the response to the hypothetical RFP ([Appendix IV](#)) estimate a potential 12% return on durable medical equipment that is no longer being used. This estimate is based on current donations of all DME from any source such as private insurance, Medicare,

Medicaid and privately purchased. In 2012, when Oklahoma first started their program they only saw 60 pieces of equipment that were purchased by Medicaid being refurbished in the first six months. This is a very small number considering that the entire non-Medicaid refurbishment network in the state saw donations along the lines of 2400 devices. There are two main activities that are implemented to avoid the low return that of the follow-up phone calls and effective marketing and outreach. Even with these in place the program only tracks new equipment being purchased and takes time to really see large return on investment by being able to rely on used instead of new equipment for Medicaid members.

Lastly, it's worth noting that while Medicaid administrative complexity may lead to a non-starter in many states it's often the vendors that struggle to see the value in refurbishment. With so many dealing with the financial burden of Medicare's competitive bidding atmosphere for vendors starting a refurbishment program may be seen as a great opportunity for non-standard models of payment. While the practicum proved to be an immensely useful learning experience for myself what I really hope happens is that the work I did allows IPAT to quickly align themselves with any conversations at the state or vendor level in developing a program that utilizes Medicaid funding to refurbished DME. With the policy analysis, business plan, response to potential RFP and the information technology framework developed IPAT should be able to rollout the program should the right legislative window of opportunity present itself.

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Appendix I: National Medicaid Policy Analysis



Introduction

What is Durable Medical Equipment (DME)? Reusable items that are used on a regular basis, without a disability and is appropriate for home use. (e.g. wheelchairs, walkers, hospital beds, CPAP machines, hearing aids, alternative communication devices)

Why is DME important?: By relying on DME people with disabilities and health conditions are able to live in their homes as compared to more costly institutional settings.

The Problem: Fifth most accessed Medicaid service at \$4.3 Billion annual expenditures. Too much of this equipment ends up in landfills, dusty attics and garage sales instead of being refurbished for others. There is no formal, mandated system to reassign DME when it is no longer being used.

Background

Refurbishing: the majority of DME purchased by State Medicaid program can be cleaned up, repaired and reused. The program is currently funded by the Technology Related Assistance for Individuals with Disabilities Act of 1998 (Tech Act). Every state and territory has a Tech Act entity whose mission is to ensure access to assistive technology for their residents.

Iowa Program for Assistive Technology: Iowa's Tech Act entity is interested in pursuing a program that tracks DME purchased by Iowa Medicaid. Through tracking, labeling and a follow-up system the program identifies equipment that is no longer needed by the Medicaid member. This equipment would then be picked up, refurbished and dropped off at the homes of people that need that particular device.

Medicaid: In the states of Kansas, Oklahoma and South Dakota their state Medicaid program specifically runs for the Tech Act entities to refurbish Medicaid-purchased DME. Reported return on investments \$3.39 for every \$1 spend on refurbishing. All three were a result of legislative interest in reducing state Medicaid budgets and all did not expand their Medicaid program through the ACA.

The Plan

Policy analysis: Research all state Medicaid programs to determine opportunities and barriers of adopting a Medicaid-funded DME refurbishment program through a partnership with their Tech Act entity.

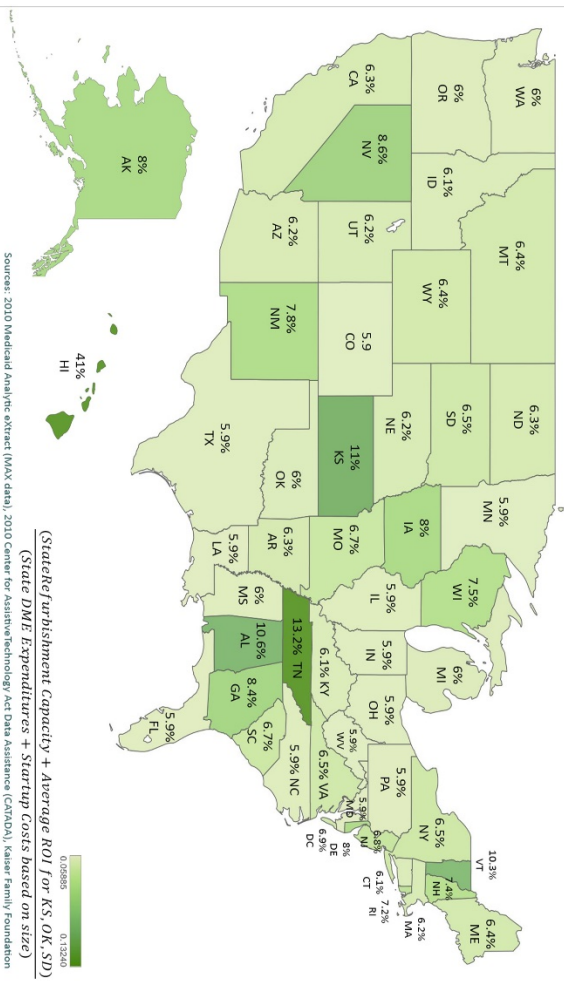
Business proposal: Develop a non-profit business plan for such a program. Typically a Tech Act subcontracts refurbishment structures. The proposal would include the organizational structure as well as a response to a potential Request for Proposal from the State of Iowa.

Database and website: Trouse accurate tracking of DME purchased by Medicaid. The program needs an information technology structure. This structure would be accessed by which Medicaid members, vendors, program employees and care coordinators would access.

Refurbishing Durable Medical Equipment to Reduce Medicaid Expenditures

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Potential Savings to State DME Fee for Service Medicaid Expenditures

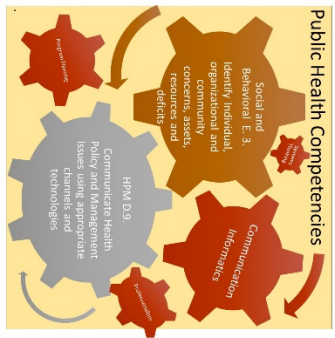


| Month: | June | July | August | September | October | November |
|-----------------------------|--|--|--|--|--|---|
| Policy Analysis | Researching state Medicaid policy via non-profit think tanks. Communicate with state Medicaid officials and think tanks. | Communicate with all Tech Act states and considered Medicaid funding with respect to On-Center that is also researching. | In-depth interviews with Kansas, Oklahoma and South Dakota Tech Act entities to learn more about their successes and challenges. | Contribute results of interviews to press release and publication. | With help from HHPR, separate and connect with relevant contacts and specific state data for any messaging values. | Analyze data and share with Pass IT/On Center and IPAT. |
| Business Proposal | Learned a Waiteman non-profit resource center. | Learn Dreamweaver as potential website. | Development on RFP based on one used by SD and OK. | Interviews with Iowa DME vendors. | Finalized business plan in collaboration with preceptor. | |
| Database and Website | Develop MS Access database. | Transform MS Access database to MySQL. | Interviews with UI Health Informatics professors to identify solutions. | Learn MS SharePoint. | Host Sharepoint pages through UHC. | |



Results (What you need to bring Medicaid funded DME refurbishment to your state)

- Legislational/ gubernatorial interest in reducing waste
- Change state legislation moving ownership of Medicaid purchased DME from consumer to state
- Extensive stakeholder meetings
- Vendor buy-in
- Organizational capacity



- ### Recommendations/Conclusions
- Can rely on existing refurbishment system
 - Reduces landfill waste
 - Increases access
 - Potential revenue stream for vendors
 - Takes a long time to get stakeholder agreement
 - Saving site minimal competitive bidding

Appendix II: Pass It On Center Report (Policy Recommendations)

**The Pass It On Center, the National Assistive Technology Reuse Center
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Acknowledgement

The Pass It On Center would like to thank Rita Stanley, Member, National Task Force on Assistive Technology Reuse, and Vice President, Government Relations, Sunrise Medical, for her contributions to this paper.

DISCLAIMER

The Pass It On Center was created and supported (2006-2013) under cooperative agreement #H235V060016 awarded by the U.S. Department of Education, Office of Special Education and Rehabilitative Services, and administered by Tools for Life, Georgia's Assistive Technology Act Program. It continues as a program of AMAC Accessibility Solutions and Research Center of the College of Architecture at The Georgia Institute for Technology (Georgia Tech.) However, the contents of this publication do not necessarily represent the policy or opinions of the Department of Education or Georgia Tech, and the reader should not assume endorsements of this document by the Federal government or Georgia Tech.

ABOUT THIS GUIDE

Access to durable medical equipment (DME) improves health and safety, minimizes doctor visits and returns to hospitals, reduces or delays assisted living and nursing home placements, and enables some people and/or caregivers to keep working. Access to DME is not always available and those who cannot obtain it fail to experience the needed outcomes and quality-of-life improvements that DME can provide. Individuals who lack access may be uninsured or under-insured, or they may have coverage but experience delays in obtaining devices. For all of these individuals, the reutilization of lightly-used DME can have great value.

PURPOSE OF THIS GUIDE

The 56 federally funded state and territorial Assistive Technology Act Programs are mandated to engage in some form of assistive technology (AT) reuse. Three of these programs engage in partnerships with Medicaid, and in a recent survey, 23 states expressed an interest in developing partnerships.

This guide is for the leaders of AT Act Programs and Medicaid programs. The purpose is not to take a position for or against partnerships between AT reuse programs and Medicaid, but to provide guidance to those who choose to pursue partnerships. The recommendations in this guide are based on best practices and the lessons learned from previous and existing programs. These recommendations could easily apply to collaborative partnerships with the Veterans Administration, education systems, Vocational Rehabilitation, private health insurance, and others.

Further, these recommendations are made with caution as healthcare in the United States is undergoing rapid changes driven by many factors, including managed care and the Affordable Care Act. These drivers will impact the provision of all DME, with pressure to contain costs. The primary consideration for reuse should not be cost containment, but rather as a possible alternative to address very specific situations such as:

- To meet needs for those awaiting eligibility decisions of third parties such as Medicaid;
- To meet needs created by losses during disasters while awaiting eligibility decisions or replacement equipment;
- To provide equipment that is not covered by customer plans (e.g., shower chairs for Medicare beneficiaries or portable ramps to support independent living);
- To serve as backup or secondary equipment (e.g., users of powered chairs like to have a backup chair for use in the event of primary equipment breakdown, or it may be desirable to provide a student user of a manual wheelchair user a second chair to leave at school);
- To meet financial needs if nearly new high-end equipment with possible warranty extensions is orphaned by an unexpected death and a beneficiary agrees to use

of nearly new equipment, then the equipment is fitted by appropriate professionals; or,

- As an alternative for specialized equipment, such as Alternative Augmentative Communication technologies for individuals with amyotrophic lateral sclerosis (ALS) where equipment is needed quickly and for shorter times.

Implementing a program that engages in safe, effective and appropriate reuse is a complex undertaking. The years of experience with different models and the pursuit of improved standards of practice through the Indicators of Quality for Assistive Technology Reuse (IQ-ATR) make the AT Act Programs potential partners for Medicaid. While a reuse partnership could be helpful, it is not a panacea for the financial impact represented by the durable medical equipment portion of a Medicaid budget. In fact, reuse presents some new challenges to manage. Who owns the device? Who refurbishes the devices? How is the beneficiary matched to an appropriate device? How is the new user tracked and notified of warnings or recalls? Who repairs the device for the new user? Careful attention to the cycle of donation-refurbishment-reassignment should be a key planning factor.

DEFINITION OF KEY TERMS

Definitions of key terms will facilitate understanding this guide.

The AT Act¹ defines **assistive technology** as “any item, piece of equipment, or product system whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.”

Durable medical equipment is a subset of assistive technology. Durable medical equipment is the primary focus of reuse partnerships with Medicaid. DME is defined in Federal regulations at 42 CFR § 414.202 as equipment furnished by a supplier or a home health agency that meets the following conditions:

- (1) Can withstand repeated use.
- (2) Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.²
- (3) Is primarily and customarily used to serve a medical purpose.
- (4) Generally is not useful to an individual in the absence of an illness or injury.
- (5) Is appropriate for use in the home.

¹ Assistive Technology for Individuals with Disabilities Act of 2004 – (29 U.S.C. 2001 et seq.)

² It is important to note that DME must have an expected useful life of three years, but Medicare will only pay to replace an item in no less than five years. This creates a potential gap of two years during which a person would need alternative funding if an item of DME cannot be reasonably repaired.

Complex rehabilitation technology is a category of devices that are fitted, programmed, adjusted or adapted for the needs of a specific individual.

Reuse takes many forms, and the Pass It On Center has encouraged the use of six definitions:

Open-ended device loan: providing a device for as long as needed

Device exchange: matching donors and users without intervention by a third party. This often takes the form of searchable databases on the Internet.

Reassignment/Redistribution: accepting equipment donations for sanitization, identifying appropriate users, and providing a device to a new consumer when the equipment matches their needs

Refurbishing: Similar to reassignment, but in addition the AT is restored as nearly as possible to its original configuration, which may include repairing and replacing parts.

Remanufacturing: Similar to refurbishing, but it involves modifying a device to a configuration other than the original manufacturer specification. (This is NOT recommended for AT reuse centers because of potential liability.)

Recycling: not in the sense of a generic synonym for reuse, but specifically to describe end-of-life breakdown for disposal and/or reuse of parts

WHAT'S IN THE GUIDE

The guide contains sections with basic information about Medicaid for those in AT Act Programs and a general history of AT reuse for Medicaid leaders. It profiles existing models for DME reuse in Medicaid, identifies some of the key Indicators of Quality for AT Reuse, and describes the process for implementing an AT reuse partnership with Medicaid.

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A. INTRODUCTION

Kansas has operated a durable medical equipment (DME) reuse partnership between the AT Act Program and Medicaid successfully for more than a decade. The Kansas Equipment Exchange (KEE) conducts a statewide equipment recovery campaign and accepts donations of lightly used DME obtained through private and public funding sources. In fiscal year 2014, the Kansas reuse program reassigned \$839,201 of durable medical equipment that was *not purchased* by Kansas Medicaid. The reuse program returned \$3.03 in value for every dollar invested in the program. Since 2003, the KEE program has received more than \$10 million of durable medical equipment from private donors, and has refurbished and reassigned more than \$8 million of used equipment.

More than \$1 million of equipment purchased by Medicaid has been recovered by the program, refurbished and reassigned to Kansans. While the term “lightly used” does not have a standard definition, generally it refers to equipment that is new, demonstration, or that is refurbished with an end product that closely meets the original specifications of the manufacturer.

The most recent census data indicates that total national expenditures on durable medical equipment exceeded \$4.3 billion. Medicaid was the second largest source of insurance funding (following Medicare) for durable medical equipment, purchasing 12.4 percent of all DME – an amount greater than all private insurance programs.³

BENEFITS OF DME REUSE

Reuse serves the uninsured and the under-insured. It can provide an interim solution for people with coverage who experience delays, or a secondary device to minimize the burden of transporting bulky devices to school or workplace. Safe, appropriate and effective reuse matches the beneficiary to the *needed* device, not “a device”. Customer satisfaction surveys of reuse programs confirm that people in need of a device who lack financial means for timely access are “highly satisfied” to have a lightly used, refurbished device. In 2014, device reuse received the highest satisfaction rating of all services from customers of the 56 AT Act Programs in all states and territories when 99.6 percent that they were “highly satisfied” or “satisfied” with the reused device.⁴

³ U.S. Centers for Medicare and Medicaid Services, Office of the Actuary, “National Health Statistics Group,” Centers for Medicare and Medicaid Services data. U.S. Census Bureau, Statistical Abstract of the United States: 2012. Retrieved 8/11/2015.

⁴ Center for Assistive Technology Act Data Assistance (CATADA). (2015). AT Act Data Brief, Issue No. 7 (2015). Retrieved 08/11/2015 from <http://www.catada.info>.

Overall, reuse provides a general benefit by reducing the consumption of natural resources (raw materials and fuel) and minimizes environmental impact by keeping usable devices out of landfills.

The financial benefits of DME reuse are measurable using return-on-investment (ROI) analysis. Traditionally, programs have used only the value of donated equipment and the cost of program operations in the computation. Some research has explored the inclusion of the value of preventing additional use of healthcare services into the ROI analysis.

SAFEGUARDS FOR BENEFICIARIES

There are many safeguards that reuse programs can incorporate to protect beneficiaries of reused DME. Some of the most important recommended safeguards include:

- Using best practices to determine whether an item is appropriate for reuse
- Sanitizing a device according to guidelines from the manufacturers and the Centers for Disease Control and Prevention (CDC) that are consistent with recommendations for sanitization of such equipment in healthcare facilities
- Performing repairs by certified technicians trained by industry suppliers
- Tracking the reassigned device to notify new users of warnings, alerts or recalls of devices
- Matching customers to the appropriate device. This sometimes requires the assistance of skilled healthcare professionals.
- Providing training to beneficiaries and caregivers in the use and care of the device and with access to user manuals
- Assuring that reuse is not used to circumvent other avenues for securing a new device

Reuse programs need clear and concise policies and procedures for assessing whether a particular item is appropriate for continued use. It is important to determine the safety and cost effectiveness of reuse of a particular device. Factors for consideration include the age of the device, the type of use, and the environment of use and possible impact of the method by which the device has been transported. The type of repair or refurbishing required to sanitize the device or to restore it to original manufacturer specifications could render reuse financially impractical.

One category of devices that poses a challenge for reuse is complex rehabilitation technology (CRT). In this category are wheelchairs that are fitted, programmed, adjusted or adapted for the needs of a specific individual. Identifying another individual who requires identical customization is very different from reassigning standard devices without modification. Reusing these devices without a professional evaluation of the precise needs of another individual is unsafe. If a program chooses to reutilize complex rehabilitation technology, policies and procedures should be in place to use appropriate allied health professionals to assure that the equipment meets the needs of the individual as identified by appropriate medical professionals and to assure that the individual has choice in the acceptance of reused equipment.

The Pass It On Center has published Indicators of Quality for Assistive Technology

Reutilization (IQ-ATR) that provide a more comprehensive exploration of a range of best practices that, if followed consistently by reuse programs, can provide safeguards to beneficiaries, reuse programs and third-party providers.

FACTORS IN ACCEPTANCE OF DME REUSE

Acceptance begins with the involvement of consumers, suppliers, healthcare professionals, agencies and organizations that serve people with disabilities, and other prospective partners in the design and development of the reuse program. It is reinforced by a commitment to high standards that result in safe, effective and appropriate reutilization. Acceptance may be diminished if a reused device is the first and only option. Choice is an important component in gaining consumer acceptance.

B. AN OVERVIEW OF ASSISTIVE TECHNOLOGY REUSE

Reuse of assistive technology is hardly a new idea. For example, the Convalescent Aid Society of Pasadena, Calif., has engaged in the free loan of home medical equipment since 1923.

A BRIEF HISTORY OF PUBLICLY-SUPPORTED AT REUSE PROGRAMS

All 50 states and six territories have assistive technology programs supported under the AT Act of 1998 as amended, 29 USC §3002.⁵ AT may be as simple as a magnifying glass or as complex as a speech-generating communication device. AT includes *durable medical equipment* (DME) such as wheelchairs and other mobility aids. The AT Act Programs serve all ages and all disabilities.

By definition, AT also includes services in which DME suppliers are not involved. Those services are often provided by physical therapists, occupational therapists, speech-language pathologists, special educators, rehabilitation engineers and other appropriately licensed, certified and otherwise qualified individuals. These services include evaluation, fabrication, customization, maintenance, arranging for funding, and training device users and the people who support them in the use of the device. Among the many categories of assistive technology, this guide focuses on the reuse of durable medical equipment.

Reuse is only one of the activities of the state AT Act Programs. The programs provide device demonstrations, device loans to try equipment for appropriate use, training on use and maintenance of assistive devices, and assistance to customers in locating financing for needed devices.

In the 1990s, some state AT Act Programs included reuse among their activities as a means of expanding access to AT, and some of those programs grew to significant size and impact in their communities. The first national conferences to explore the “hidden resource” of AT reutilization took place in 1999 and 2000. From that point, the call to expand reuse gained support. A “perfect storm” of factors converged for promoting the expansion of reuse: the reauthorization of the AT Act in 2004 with reuse as a *required* activity, the New Freedom Initiative to allow people to live as independently as possible, and the aftermath of Hurricane Katrina with issues surrounding the evacuation of people with disabilities and users of AT. John Hager, Assistant Secretary of Education and himself a user of AT, championed the cause of AT reutilization.⁶

⁵ Center for Assistive Technology Act Data Assistance (CATADA). (2012). Device Reutilization Programs Activity Summary Report (2012). Retrieved 01/07/2014 from <http://www.catada.info>.

⁶ For more information on the history of AT reutilization, see article by Kniskern and Phillips, Technology Reutilization: What We Know Today, *Assistive Technology Outcomes and Benefits*, Fall 2008.

In 2006, the Office of Special Education and Rehabilitative Services (OSERS) of the U.S. Dept. of Education promoted the cause of AT reutilization through 13 grants. Twelve grants were given to reuse programs in twelve states for the development of “demonstration” projects to benefit the reuse community and serve as models. The other grant created a national technical assistance center to serve the demonstration grantees and all other reuse programs. The Pass It On Center, administered by Tools for Life, Georgia’s AT Act Program, has served the reuse community since that time. Also that year, a National Conference on AT Reutilization was hosted in Atlanta.

STATE AT ACT PROGRAMS PARTNER TO EXPAND CAPACITY

With limited federal funding, most AT Act Programs promote reuse through partnerships with nonprofit organizations whose customers benefit from reuse. Partners include local chapters of nationally-known organizations such as Easter Seals and United Cerebral Palsy, Centers for Independent Living, foundations dedicated to assisting people with disabilities, rehabilitation centers, government agencies, faith-based ministries and civic organizations. Reuse programs and their partners sometimes share facilities, staff or other resources to minimize costs. For example, Alabama’s STAR program has sites in seven cities and a different partner in each. Those partners include Easter Seals, United Cerebral Palsy, Goodwill Industries, a rehabilitation center and an association of Baptist churches. The reuse programs are able to operate with minimal funding from the state AT Act Program and shared resources from the local partner.

The Pass It On Center (PIOC) supports a voluntary database of Reuse Locations on its website to identify reuse programs beyond the State AT Act Programs. The online database permits the creation of a profile specifying name, location, types of reuse activities and contact information for a reuse program. Users may locate programs by clicking on a map of U.S. states and territories or narrow the search by selecting type of reuse activity. At the time of this report, the database included 223 program profiles.

Some programs have unusual partners. For example, in Wisconsin a reutilization program partners with a state prison for the refurbishing of wheelchairs. Selected inmates are trained to manufacturer certification level to repair and refurbish lightly-used wheelchairs. When ready, the wheelchairs are returned to the reuse program for distribution.

In addition to leaders from reuse programs, industry representatives Rita Stanley, Vice President, Government Relations of Sunrise Medical and Caroline Van Howe, Chief Operating Officer, the Assistive Technology Industry Association (ATIA), are members of the National Task Force on AT Reuse. The Pass It On Center encourages individual programs to work with local suppliers of AT. Manufacturer programs are the source of training for most technicians who perform repair and refurbishing activities. Some programs have found suppliers to be sources of donations in the form of discontinued, but usable, devices.

SCOPE OF REUSE

The definitions noted earlier are essential to reporting reutilization activities for the Center for Assistive Technology Act Data Assistance (CATADA), the approved data collection system for statewide AT programs. (The data is available at <http://catada.info>.) Voluntary data collection began in 2006 with formal reporting implemented in February 2007. The 2008 report (Oct. 2007 - Sept. 2008) is the first year of complete reporting.

In the 2014 fiscal year, 43,713 consumers received a total of 57,745 reutilized devices from all 56 AT programs with an overall savings of \$25.2 million. The majority of AT devices provided through reuse programs (85% of all devices) supported mobility, seating and daily living. Most of the activity (72%) was in the area of recycling, refurbishing and repair services, compared to device exchange (6%) and open-ended loans (21%).⁷

CATADA data reflects only the reutilization activities of the 56 state and territorial AT Act Programs and their reuse partners. It does not include data from all 223 programs profiled in the Locations Database.

The valuation of devices for reporting was an issue for many reuse programs, and because no standard exists for calculating the depreciated value of used assistive technology (i.e., nothing comparable to an automobile “blue book,”) many programs use a percentage (usually 70 or 75%) of the manufacturer’s suggested retail price (MSRP) to represent the cost of purchasing a new device, and therefore the savings to the consumer. One flaw in this choice of valuation is that most devices are not purchased by individuals at MSRP, but by third-party payers (private insurance companies, Medicare, Medicaid, the Veteran’s Administration and other government programs) that pay far less than 70-75 percent of the MSRP for the new device.

⁷ Center for Assistive Technology Act Data Assistance (CATADA). (2015). AT Act Data Brief, Issue No. 7 (2015). Retrieved 08/11/2015 from <http://www.catada.info>.

2014 Reuse through AT Act Programs (Source: CATADA)

| Type of Assistive Technology | Average Savings Per Device | Percent Devices | Number Devices | Total Savings to Consumers |
|---|----------------------------|-----------------|----------------|----------------------------|
| Mobility and seating | \$585.06 | 51 | 29,210 | \$17,089,511 |
| Daily living | 171.84 | 34 | 19,481 | 3,347,600 |
| Computers and related | 231.45 | 5 | 2,711 | 627,471 |
| Environmental adaptations | 470.18 | 2 | 1,337 | 628,626 |
| Vision | 444.58 | 2 | 1,270 | 564,614 |
| Recreation, sports and leisure | 124.91 | 2 | 1,122 | 140,150 |
| Learning/cognition | 241.23 | 2 | 959 | 231,339 |
| Hearing | 273.26 | 1 | 834 | 227,901 |
| Speech communication | 1,735.94 | 1 | 705 | 1,223,836 |
| Vehicle modification and transportation | 73,810.06 | <1 | 16 | 1,180,961 |
| Total | \$ 395.31 | 100% | 57,745 | \$25,262,009 |

TECHNICAL ASSISTANCE TO EXPAND AT REUSE

In 2006, the U.S. Department of Education's Office of Special Education and Rehabilitative Services awarded twelve AT demonstration grants to programs in different states and a grant for the creation of a national technical assistance center for AT reuse. That began the process of expanding AT reuse and making it safer and more professional. Prior to 2004, independent living centers, nonprofit organizations serving people with disabilities, faith-based organizations and other groups engaged in AT reuse through informal "loan closets" of durable medical equipment or programs for "recycling" computers.

The intent in providing financial support for the expansion of AT reuse through the demonstration grants and a technical assistance center was *not* to create a new regulated reuse bureaucracy or to undermine consumers' options for getting new AT from existing suppliers, but to serve those who could not otherwise acquire AT devices.

The expansion of reuse through Medicaid raises a serious concern about the possibility of the elimination of consumer choice.

The objective of Pass It On Center activities is to expand safe, appropriate and effective reuse of AT devices of all types. It provides technical assistance for the reuse activities of the 56 state and territorial AT Act Programs and for numerous nonprofit organizations that engage in some form of AT reutilization.

In its first six years, the Pass It On Center built a significant infrastructure of resources to promote AT reuse, a practice with the potential to have major social and economic impact. It addressed issues of national significance, provided education and technical assistance to new and existing reuse programs, created tools for programs and customers, developed measures of outcomes, and provided education about strategies for sustainability. This was achieved with cooperation and support from AT reuse programs throughout the states and territories.

QUALITY ASSURANCE AND LIABILITY CONCERNS IN REUSE PROGRAMS

One key concern in developing partnerships is the potential liability from the assignment of inappropriate, unsafe or unsanitary equipment. PIOC focuses on the sharing of best practices for AT reuse. The initial focus was the development of a website with a Knowledge Base that focused on key issues for operating a reuse program: sanitizing devices, matching devices to customers, developing sustainable programs. Working with a national team, it developed Indicators of Quality for AT Reuse (IQ-ATR) and created an Online Program Assessment Tool to promote the use of the IQ-ATR to measure progress.⁸

PIOC has presented over 50 webinars without charge for reuse professionals throughout the country. These are qualified for CRC and CEU credits and archived on the website for retrieval and use on demand.⁹ PIOC became an Alliance Partner of the Assistive Technology Industry Association, presenting a strand of sessions on reuse topics at each annual national conference to expand knowledge about reuse.

⁸ Pass It on Center for Assistive Technology Reutilization. (2013). Indicators of Assistive Technology Reutilization (IQ-ATR). Retrieved 01/07/2014 from <http://www.passitoncenter.org/IQATRreuse/>.

⁹ Pass It on Center for Assistive Technology Reutilization. (2013). Webinars. Retrieved on 01/07/2014 from <http://passitoncenter.org/Webinars.aspx>.

C. MEDICAID: WHAT IT IS, HOW IT WORKS

Medicaid is a public insurance program operated by states within broad federal guidelines. The broad flexibility results in differences in eligibility and benefits from state to state. Both Medicaid and Medicare are public health insurance programs created by the Social Security Amendments of 1965 (P.L. 89-97). Medicare was designed as a hospital insurance program to cover most of the elderly (over age 65). Medicaid is a means-tested program with a combination of financial and categorical eligibility requirements. Some senior citizens are eligible for both Medicare and Medicaid.

Nationally, Medicaid pays for the delivery of 40 percent of all new babies, and provides healthcare for half of America's 62 million low-income children, 11 million non-elderly, low-income adults, 8.8 million non-elderly individuals with disabilities, and 4.6 million low-income seniors who are also enrolled in Medicare.¹⁰

Physicians, hospitals and other healthcare providers are not required to participate in Medicaid, and many choose not to do so. States determine the reimbursement rate for services and the recent recession has resulted in curtailed and delayed reimbursements.

HOW MEDICAID IS FUNDED

Medicaid, as originally implemented, was a program in which states received guaranteed federal financial support for part of their Medicaid program costs. The general federal contribution was based on a comparison of the state's per capita income with the national average, a formula called the Federal Medical Assistance Percentages or FMAP. No state received less than 50 percent match under this formula, but it resulted in significant funding differences based on income. A wealthy state might receive only a 50 percent match, while a poor state might get as much as 75 percent. The federal share averaged 57 percent of costs between 2001 and 2011.

A different formula is used to compute contributions for the children's program. The Children's Health Insurance Program (CHIP) was added in 1997 to encourage states to insure more children, and it uses a more generous formula. That formula starts with the FMAP numbers, and then lowers the state's share of spending by 30 percent. The result

¹⁰ Medicaid Moving Forward, Issue 1. Retrieved from [http://Medicaid.gov/State-Resource-Center/Events and Announcements/Downloads/MMF_Jan-Dec-2012_FINAL.PDF](http://Medicaid.gov/State-Resource-Center/Events%20and%20Announcements/Downloads/MMF_Jan-Dec-2012_FINAL.PDF), Aug. 12, 2015.

is a higher federal share that ranges from 65 percent to 84 percent, depending on the state. The national average is about 70 percent.¹¹

With federal encouragement and incentives, states have implemented different delivery system models including managed care (with primary care case management systems, managed care organizations, prepaid health plans, and long-term services and supports), patient-centered medical homes, health homes, and accountable care organizations. This array of delivery models is combined with a mixture of payment models ranging from the traditional fee-for-service to pay-for-performance, episode of care, global bundling and others.¹²

ELIGIBILITY

The Patient Protection and Affordable Care Act (commonly called the Affordable Care Act or ACA) was signed into law in March 2010. It uses insurance exchanges and Medicaid to provide healthcare to millions of uninsured Americans. Prior to its passage, 17.87 percent of the U.S. population was estimated to be uninsured. A 2012 study by the Commonwealth Fund found that one in four working-age Americans went without insurance at some point in 2011, often as a result of unemployment and other job changes.¹³

Estimates were that about 17 million more people will become eligible for Medicaid because it will cover people with slightly higher income limits. To facilitate the transition to this expanded coverage, the federal government started by paying all of the costs for those newly-eligible in 2014, but the percentage gradually will decrease to 90 percent over a five-year period and remain at that level. In states that already have expanded their Medicaid programs with state money, the federal share was to be slightly lower than 90 percent in 2014 and move up to 90 percent by 2019. The Medicaid expansion is projected to cost the federal government \$627 billion from 2012 through 2021, according to the Congressional Budget Office. The Affordable Care Act did not change the existing FMAP or CHIP formulas, leaving states with three different means by which their federal funding for Medicaid is calculated.

The implementation of ACA has seen the rate of uninsured individuals decline and the number of Medicaid beneficiaries rise, especially in those states that chose to expand

¹¹ Courmoyer, Caroline. Medicaid Explained: How a Blended Rate Would Work. *Governing the States and Localities*. Retrieved February 18, 2013, from <http://www.governing.com/blogs/politics/Medicaid-Explained-How-a-Blended-Rate-Would-Works.html>

¹² The Kaiser Commission on Medicaid and the Uninsured (2015). *Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts*, The Henry J. Kaiser Family Foundation. Retrieved 8/13/2015 from

¹³ Collins, S. R., Robertson, R., Garber, T. & Doty, M.M. (2013) *Insuring the Future: Current Trends in Healthcare Coverage and the Effects of Implementing the Affordable Care Act*. Retrieved from <http://www.Commonwealthfund.org/Publications/Fund-Reports/2013/Insuring-the-Future.asp>

Medicaid. The post-implementation projection is that 14.22 percent of the population will remain uninsured.¹⁴ As of the end of the 2015 Affordable Care Act open enrollment period, 11.7 million people had signed up for coverage in a Health Insurance Marketplace. The rate varied widely across states when looked at as a share of the “potential market”, ranging from a high of 70% in Vermont and 64% in Florida to lows of less than 25% in Iowa, South Dakota, Minnesota, North Dakota, Hawaii, and Alaska.¹⁵

Any person who meets the eligibility requirements (always income-based in relation to the federal poverty line combined with other qualifying factors) has the right to receive Medicaid coverage (that is, to become a “beneficiary”). To receive federal funding, states must cover five mandatory populations:

- (1) Children under age six,
- (2) Children aged 6-18,
- (3) Pregnant women,
- (4) Parents whose income is within the state’s eligibility limit for cash assistance that was in place prior to welfare reform; and
- (5) Most seniors and persons with disabilities who receive cash assistance through the SSI program.

Every state covers at least one optional population. Those include:

- a) Pregnant women, children and parents,
- b) Seniors above 65 and people with disabilities,
- c) Other “medically needy” individuals whose medical expenses reduce their disposable income to below the eligibility limit.¹⁶

Over the years since its creation, Medicaid coverage has been extended beyond the original target of low-income citizens under the age of 65. In the 1970s Medicaid began to cover care for people in intermediate care facilities, and it established the Supplemental Security Income (SSI) Program of Assistance for the Elderly and Disabled. In 1981, patients under Medicaid were given more flexibility and choice in selecting health care providers through waivers for home and community-based care.

¹⁴ Kiernan, John S. *Rates of Uninsured by State Before and After Obamacare*. Retrieved 8/18/2015 from <http://wallethub.com/edu/rates-of-uninsured-by-state-before-after-obamacare/4800/>.

¹⁵ Mapping Marketplace Enrollment (2015). Kaiser Family Foundation. Retrieved 8/19/2015 from <http://kff.org/interactive/mapping-marketplace-enrollment/>.

¹⁶ *Medicaid and CHIP Information*. Retrieved February 18, 2013, from www.medicaid.gov/Medicaid-CHIPProgramInformation/ByPopulation.html.

Also that year, states were required to pay hospitals that provided care to low-income patients. This was to encourage hospitals to serve everyone equally and stop the practice of diverting low-income patients to a limited number of public hospitals. In 1985, pregnant women were given coverage if they wanted it. Illegal immigrants were covered for certain emergency situations starting in 1986. In 1989, states were given the option to add dental coverage. Coverage was expanded again in 1991 to permit states to manage the cost of prescription drugs. Then, in 2000, coverage was extended to women with breast or cervical cancer, regardless of income.

Not all of the expansions are mandatory, so significant differences remain among the state programs. A state may elect to cover “optional” populations and receive additional funding. As noted earlier, states may cover different populations beyond those mandated for federal matching funds. They may choose to provide a different scope of services for the populations that they choose to cover. Each state has different rules for eligibility and services for its Medicaid beneficiaries.

NOTE: Refer to www.Medicaid.gov or the state Medicaid program website for more information about the eligibility rules and coverage for a specific state.

CURRENT ECONOMIC STRESSES

Because Medicaid is an open-ended entitlement program, everyone who meets the state eligibility rules is entitled to receive services. When unemployment increases and the economy worsens, the number of eligible persons increases and imposes additional financial strain on state and federal budgets. It should be noted that the healthcare expenditures by Medicaid programs do contribute to local and state economies, and most programs calculate and report the economic impact of those tax dollars. Even so, the issue now is the ability to pay for the projected increase of eight percent per year in the cost of Medicaid in an era of declining tax revenues.

MANAGED CARE AND ITS POTENTIAL IMPACT ON DME AVAILABILITY

Many states are shifting from fee-for-service to managed care models for their Medicaid programs. Managed care models account for 70 percent of Americans enrolled in Medicaid. In a managed care delivery system, the state contracts with organizations to provide services and this often becomes the only method of accessing devices and related services. In recent years, state agencies have sought waivers to move previously exempt groups, such as people with disabilities and the elderly, to mandatory managed care programs. From the state perspective, this model ensures quality and increases efficiency while expanding home- and community-based services. Studies of the outcomes show significant differences among managed care organizations. For states that have included persons with disabilities in the Medicaid Managed Care coverage, training to providers regarding identification/barcoding of new Medicaid purchased equipment through the managed care contract, working with Managed Care case coordinators to balance the new versus lightly used equipment decisions, and ongoing communication become extremely important to the ongoing success of the equipment reutilization program.

The reimbursement rates for DME purchased by Medicare, Medicaid programs and managed care organizations have been reduced significantly. This poses a significant threat to the availability of DME, both new and lightly-used equipment available for reuse. According to Rita Stanley of Sunrise Medical, some defined reimbursement levels for specific items of DME are now below manufacturing cost. If not corrected, this will lead to the discontinuation of production of those items.¹⁷

Another concern in the DME reuse community is the implementation of Medicare's competitive bidding for DME suppliers. This affects individuals with dual eligibility for Medicare and Medicaid, and critics expect the limiting of the number of suppliers to have a negative impact on service, thereby resulting in a reduction in access, especially in rural communities. Should it result in a reduced amount of new equipment being purchased, it would have a limiting impact on the number of devices available for reuse.

¹⁷ Pass It On Center audioconference, 8/11/2015.

D. OVERVIEW OF MEDICAID EXPERIENCE WITH REUSE

The Kansas Equipment Exchange (KEE) Reuse Program began as a partnership with Medicaid in 2003, and is cited often as a model alliance. Assistive Technology for Kansans (ATK), the state Assistive Technology Act Program, operates five regional Assistive Technology Access Sites that serve as the hub and provide the infrastructure for many Kansas health and disability programs. The five ATK sites, an affiliate site in Garden City, and a network of more than 36 program partners comprise the statewide system. A staff of 26 Assistive Technology professionals serves as the donation and distribution centers for the equipment reuse program. The Medicaid program supports inventory tracking of all devices donated into the program. It also pays DME suppliers through the KEE Program to refurbish devices for Medicaid beneficiaries. The KEE Reuse Program has been recognized as a best practice program by the Centers for Medicare and Medicaid Services (2007)¹⁸ and has received state and national recognition. The KEE Reuse model, with some variation, has been adopted by Oklahoma. In addition to the statewide reuse programs modeled in Kansas, other initiatives support reuse while stopping short of a refurbishing partnership. Some Medicaid programs support stickers (placed on devices purchased with Medicaid funds) that either support the retrieval of the device, or encourage the donation of the device into a reuse program when it is no longer needed (e.g., Virginia pilot program.) Others pay for certified repair technicians in reuse programs to perform repairs to Medicaid- purchased equipment (e.g., at Paraquad in St. Louis).

The need to control expenditures has led to the exploration of many cost-containment strategies for publicly funded healthcare in recent years, including managed care. A significant portion of the total amount spent on durable medical equipment is paid by Medicaid programs. Governors are looking for opportunities to reduce state budgets and healthcare is among the biggest expenses. A significant percentage of Medicaid beneficiaries are people who need assistive technology. Some states have chosen to make optimal use of resources by recovering and reutilizing functional durable medical equipment purchased with tax dollars and no longer needed by the original recipients, whether Medicaid beneficiaries or children in the Birth to Three Early Intervention Program. As the experience of successful assistive technology reuse programs has shown, they have an opportunity to benefit from the expanded world of donated devices purchased by individuals and private payers. Customers benefit from DME reuse through access to properly sanitized and refurbished equipment that meets the needs identified by their physicians. By accepting reused devices as part of the solution, they extend the Medicaid budget.

¹⁸ *KHPA Medicaid Transformation 2008*, a report of the Kansas Health Policy Authority (January 2009), Chap. 4, p. 33. Retrieved March 7, 2013, from http://www.khpa.ks.gov/medicaid_transformation/download/2008/KHPA_2008_Medicaid_Transformation.pdf

While expanded reuse of DME is an opportunity to address a major national financial need while contributing to the environment, it has practical limitations. Profit margins in the durable medical equipment industry already are so low that many services have been eliminated. Substantial drops in volume would result in insufficient revenue to sustain operations, especially for small suppliers. Again, this involves a healthcare model that limits the number of suppliers. That is why it is worthwhile to examine and discuss models of successful partnerships between Medicaid programs and AT Act Reuse Programs.

A few states have engaged in successful equipment reuse within Medicaid programs for many years, with Kansas and Oklahoma having the broadest coverage and highest volumes of reuse. This is entirely separate from the purchase of new DME devices by Medicaid for program beneficiaries. Reuse programs may be used to fill the needs of *some* beneficiaries, but this is dependent on two key factors. First, the beneficiary must be willing to accept a lightly-used device. Second, an appropriate device (one that meets the specific needs of the person) must be available in inventory. The models for device *reuse* within Medicaid vary by state.

DRIVERS FOR REUSE

Some assistive technology devices are lightly used, sometimes because the need is brief and the person recovers, or sometimes because the user dies. Other devices are acquired for people with long-term or permanent disabilities and the device may no longer have useful life when the original owner requires another device or dies. Reuse affords the opportunity to recover that lightly-used DME for reutilization by people in need who lack the resources to acquire new devices, for use as an interim solution while waiting for new DME, or as a second device for school or the workplace to free the user or caregiver from undue burden in transporting a device. The financial implications for government-funded healthcare programs are significant. Medicaid is the third-party partner with the most activity occurring followed by the Veteran's Administration and Vocational Rehabilitation.

DIFFERENT MODELS FOR REUSE

Reuse of durable medical equipment within Medicaid has taken several forms. Kansas has one of the oldest continuous programs, which was started in 2003. The Kansas Equipment Exchange, a partnership between Medicaid and Assistive Technology for Kansans, reclaims and refurbishes Medicaid-purchased equipment and other donated devices and distributes those devices free of charge to eligible citizens. The Oklahoma Durable Medical Equipment Reuse Program, which was funded in late 2011, follows a similar model.

In 2009, Vermont launched a program to retrieve eight categories of DME when no longer needed by Medicaid beneficiaries. All DME suppliers placed stickers on new devices requesting return to Medicaid when no longer needed, and each beneficiary was asked to sign a document acknowledging that Vermont Medicaid retained ownership and that it would be returned when no longer needed.

In Virginia, Medicaid is represented on the AT Act Program Advisory Council, and thereby

familiar with the networked reuse efforts in the state. In 2011, the Commissioner of Vocational Rehabilitation asked Medicaid to participate in a pilot program to recover equipment. DME vendors in the Roanoke area placed stickers on Medicaid-purchased devices asking that they be returned to the Virginia Reuse Network. More research is needed to determine whether placing stickers on devices is consistently useful for state programs. Data from Kansas showed that most devices donated to the KEE program, and particularly the devices that were in the best condition and of most value for reassignment came from non-Medicaid sources. This was also the experience in Oklahoma.

Paraquad, one of the nation's oldest Centers for Independent Living, operates a large AT reuse program in St. Louis. It partners with Medicaid to provide repair services to beneficiaries using certified technicians who refurbish donated AT.

Medicaid has partnered with other programs in limited ways, e.g., donating Medicaid-purchased equipment to the Delaware AT Initiative partnership with Goodwill Industries.

KANSAS EQUIPMENT EXCHANGE, 2003

Kansas was an early innovator when it included AT reuse in its Medicaid program through the Kansas Equipment Exchange (KEE). The collaboration of Kansas Medicaid with Assistive Technology for Kansans (ATK, the state AT Act Program), specified in a contractual agreement, has resulted in an exemplary statewide model that includes durable medical equipment suppliers, a network of 36 partner organizations providing services to consumers, and the consumers themselves.

Origin. This partnership arose from several factors. Kansas legislators expressed concern when seeing durable medical equipment in yard sales at a time when the economy was tightening and the Medicaid program proposed an \$11 million DME budget. The ongoing relationship between the Medicaid program and ATK resulted in discussions of a formal partnership and an application for a grant from the National Institute on Disability and Rehabilitation Research (NIDRR) which recently became the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). The proposed Kansas Equipment Exchange received a grant of \$449,478 to develop a statewide, cost-neutral DME reutilization program from October 2001 through September 2004.

As with most states, creating a reuse program required a change in state policy regarding equipment ownership. (In some states this may require a change in law or regulation to permit used devices within the Medicaid program.)

Design. The design of the program included consumers, commercial DME suppliers, the ATK staff and Advisory Council and staff from the Health Care Policy Authority (Medicaid). The partners and collaborators identified a set of quality indicators on which the program would be built. Those indicators included:

Commitment to quality equipment. All donated and reclaimed equipment would be sanitized, repaired and refurbished as needed. The repair and refurbishing would be performed by qualified vendors who backed their work and would be paid for their services.

Equal access. All consumers, regardless of geography, income, disability, health conditions or type of DME needed would have equal access to equipment. This was to be accomplished through regional distribution centers. Recognizing that DME is essential to quality of life and influences consumers' perceptions regarding safety, home and family relationships and community involvement, KEE determined to provide timely access but not an urgent care program. The original goal was to turnaround inventory within 90 days. To reduce transportation barriers that limit consumer access, the program employed multiple strategies: (1) Staff and volunteers from disability and nondisability organizations were used to pick up and deliver equipment. (2) DME suppliers were paid to deliver equipment when the situation warranted. (3) Couriers were sometimes hired to pick up or delivery equipment.

Sustainability. The program was designed to be sustainable over time after the NIDRR grant ended. To accomplish this, the program had to prove that it was cost-effective, or at least cost-neutral, for agencies to continue to participate. The equipment had to be of sufficient value to warrant refurbishment and tracking. A broad category of DME was identified for acceptance, but the focus was placed on high value, lightly used devices.

Public acceptance. Emphasis was placed on strategies to avoid the high national rate of AT/DME abandonment. Consumers were linked to local DME suppliers for maintenance, repair or reassessment. They were linked to the Tech Act Program, ATK, for additional demonstration and training in the proper use of devices. It was found that the public readily viewed reuse of DME as a solution. This was furthered by the involvement of nondisability partners in volunteer regional networks.

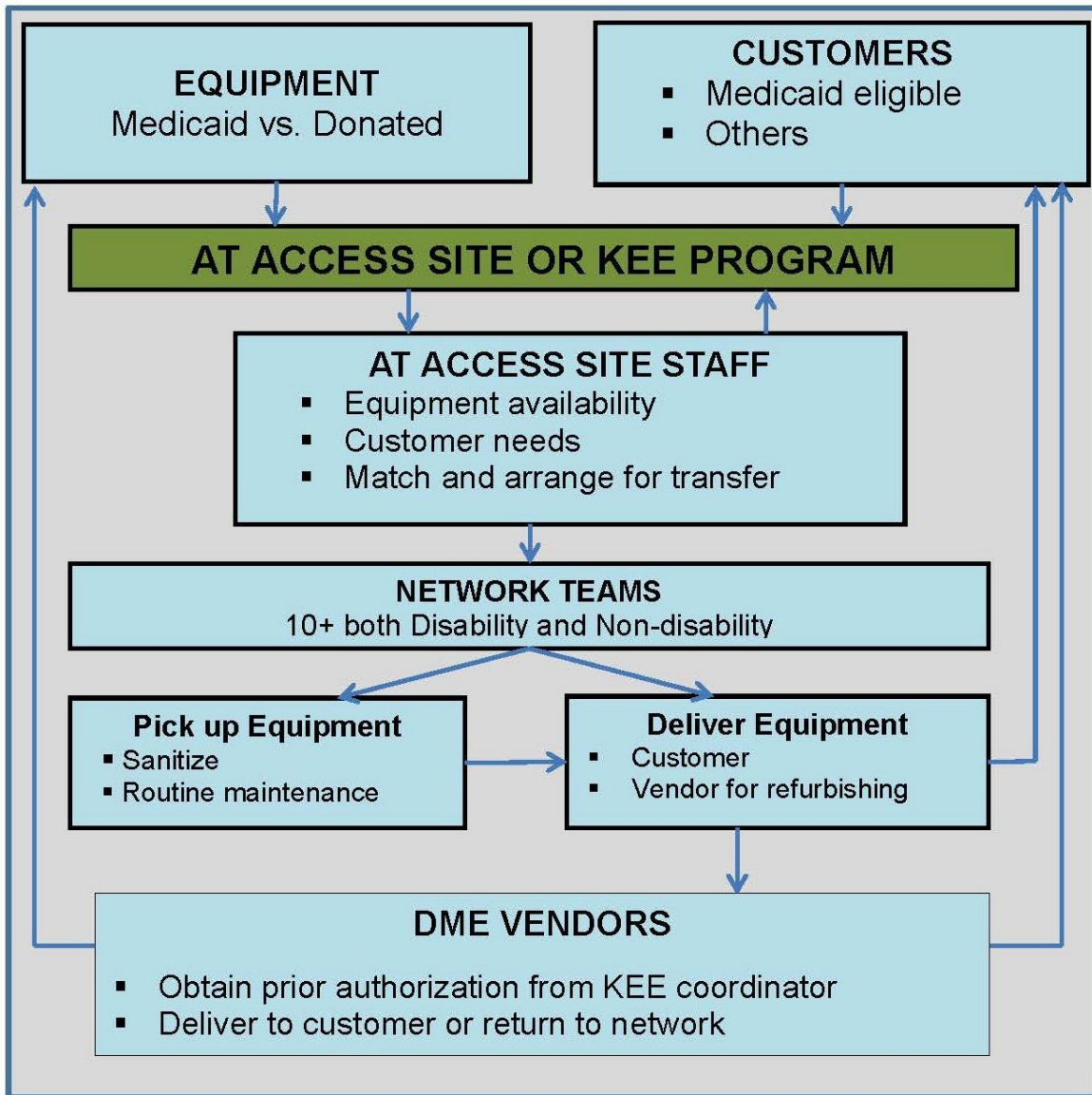
Funding. After the initial grant, KEE was funded through the Medicaid program, the Department of Administration and the University of Kansas, the lead agency for the Tech Act Program. The 2014 budget of \$554,170 represents equal state and federal funding.

As noted earlier, the Kansas reuse program was identified as a best practices program that saved the state a significant amount of money¹⁹ through reuse in the Medicaid program. Sara Sack, PhD, director of the Kansas AT Program and a member of the National Task Force on AT Reuse, became an often-requested consultant for states

¹⁹ Ibid.

interested in the inclusion of AT reuse in Medicaid programs. To date she has consulted with 18 states.

Kansas Equipment Exchange Operations Model



Dr. Sack advocated the application of standard return-on-investment analysis to AT reuse. Using only the value of the equipment as reported in CATADA data (a percentage of the MSRP), the return on investment in FY 2014 was \$3.03 for every dollar spent in the Kansas program. The program recovered Medicaid-purchased equipment valued at \$35,602 plus general donations of equipment valued at \$1,000,357, for a total of 997 devices valued at \$1,035,959. All of those devices were available for reassignment to Medicaid beneficiaries; 854 were reassigned for a total savings of \$ 839,201 that year.

Operations. In twelve years of operation, the Kansas program developed broader community involvement and more comprehensive coverage. Some of the newly- developed programs are following this model and one of those will be examined later in this document.

Eligibility. Those eligible to receive equipment from KEE are Medicaid beneficiaries, those Medicaid eligible and those likely to become eligible, and those eligible for limited medical coverage by virtue of limited income and assets, or their disability as determined by Medicaid and their pending application for disability through the Social Security Act. Equipment reuse provides increased coverage to clients and services for individuals who would not be covered otherwise, especially the uninsured and under-insured.

Goal. The goal of KEE is to track, recover, refurbish and reassign high-cost, lightly-used durable medical equipment.

Staffing. KEE operates with a modest staff. The Director of Assistive Technology for Kansas donates time to oversee the program. (AT reuse is one of the mandated activities of the Tech Act Programs.) In addition, KEE has a full-time coordinator and an average of 20 hours per week paid staff at each of the five AT Access Sites. Network team volunteers fill other needs and may be reimbursed for mileage and/or time. Repair and refurbishing is contracted to commercial suppliers.

Addressing liability concerns. The greatest reluctance to embark on a reuse program usually stems from liability concerns. In Kansas these have been addressed by:

1. Maintaining an adequate budget for refurbishment
2. Use of certified vendors for repairs and refurbishing
3. Policy and procedure manuals and training staff and volunteers in appropriate procedures for sanitization, maintenance, pickup and delivery practices to ensure fidelity
4. Requiring professional consultants to match certain categories of equipment (gait trainers, standers, CPAPs, BiPAPs, feeding pumps)
5. Use of a disclaimer of liability on the website and a customer waiver of liability on the delivery form
6. Tracking equipment and accessories model and serial numbers to alert beneficiaries of any manufacturer or FDA recalls.

Acquiring equipment for reuse. Medicaid-purchased devices are stickered with requests to return to the program when no longer needed and some tracking is done to accomplish this objective. Public donations of devices in all categories of DME are accepted by KEE and these accounted for 97 percent of the donations in Fiscal Year 2014. The donations were acquired by conducting public awareness campaigns and partnering with other organizations in donation drives. In addition to special collection drives, devices may be donated at any time by calling a toll-free number at one of the regional access sites to arrange for pick-up.

Devices accepted for donation. Kansas accepts the following devices and makes a special effort to acquire bariatric devices that are in high demand:

- Augmentative Communication Devices (ACDs) (Medicare and Medicaid identify this technology as SGD- Speech Generating Devices)
- Bath benches and shower chairs
- Bi-PAP and CPAP machines
- Commodes
- Feeder seats
- Feeding pumps
- Gait trainers
- Hospital beds
- Patient lifts
- Scooters
- Wheelchairs, manual and power

The Kansas Reuse Program budget includes funds for KEE to track *all* donated devices, whether purchased with Medicaid funds or other sources. The database used for inventory tracking also tracks the assignment of devices so that consumers can be contacted if FDA alerts or recalls are issued.

Kansas Equipment Exchange: Data from Start-Up Period and Recent Years

| Year | Consumer Requests | Donations | Value of Donations | Reassigned Devices | Value of Reassigned Devices |
|--------------------------|--------------------------|------------------|---------------------------|---------------------------|------------------------------------|
| Year 1 (2003) | 421 | 275 | \$325,568 | 127 | \$183,941 |
| Year 2 (2004) | 631 | 338 | \$384,054 | 269 | \$320,045 |
| Year 9 (2011) | 1,158 | 777 | \$1,126,051 | 701 | \$949,206 |
| Year 12 (FY 2014) | 1,483 | 937 | \$1,035,959 | 854 | \$839,201 |

(Source: Kansas Equipment Exchange)

DME is repaired and refurbished by certified technicians at commercial DME suppliers. Dozens of suppliers have participated in the Kansas program. Medicaid reimburses the cost of refurbishment of durable medical devices. Other funds are used to pay for refurbishing other types of assistive technology. DME suppliers champion KEE, often promoting the program to consumers (who would not have the funds to be their customers otherwise) and recruiting other DME suppliers. KEE brings business to them through refurbishing and as repeat business from KEE consumers who need additional equipment and supplies.

The Medicaid program has priority on use of devices in inventory and may place a hold on specific high-value equipment. However, after 120 days in inventory (an extension from the original period of 90 days), if no hold exists and no KEE consumer is located

who needs the equipment, then the equipment is distributed to other reuse partners in the state network for reassignment.

A professional consultation is required for some devices. KEE staff members are trained to match consumers with appropriate devices. Users are instructed in the proper use of the assigned device(s), and follow-up calls are placed to all device recipients. Consumer satisfaction is tracked.

In FY 2014, 97 percent of the inventory came from general donations. All of those were available to Medicaid beneficiaries. Kansas recovered Medicaid-purchased equipment valued at \$35,602 and additional donations purchased with public or private funds valued at \$1,000,357.

VERMONT MEDICAID EQUIPMENT REUSE PROGRAM, 2009

The Vermont Assistive Technology Program (VATP) initiated a partnership with Vermont Medicaid in 2009. The purpose of the partnership was to establish a system for retrieving and redistributing Medicaid purchased equipment. A project was developed and implemented through a Memorandum of Understanding (MOU) between the VATP and the Department of Vermont Health Access (DVHA), which houses Vermont Medicaid. The project was in place from 2009 until 2014.

In Vermont, Medicaid retains ownership of equipment at all times. The Medicaid Equipment Reuse Project was developed with this rule central to its operations. The project began with DVHA identifying eight categories of equipment that would be tagged for return when the original recipient no longer needed the item. These categories included AAC devices, manual wheelchairs, power wheelchairs, power operated vehicles, standers, electric beds, shower commode chairs and lifts. Concurrently, DVHA began a process of having beneficiaries sign a document acknowledging that Vermont Medicaid retains ownership and that the equipment would be returned when it was no longer needed. Each durable medical equipment vendor in Vermont was informed of the new process and began placing stickers with return information on these eight categories of Medicaid purchased devices.

Once a device was returned to Medicaid, the VATP was alerted. In turn, the VATP facilitated the transfer of the equipment to area non-profits for refurbishing and redistribution. Technical Assistance was provided to the non-profits regarding Indicators of Quality for Reuse and the VATP acted in the role of coordinator among Medicaid, non-profits, and the new recipient of the equipment. This distributed storage model was utilized for the five years that the project was in operation.

Recipients of the redistributed equipment were generally individuals awaiting eligibility determination for Medicaid, persons who could not afford co-payments for equipment, or those who needed a second device.

Although this program provided an average of \$156,768 annually in savings directly to Vermonters on the purchase of durable medical equipment, the VATP ended the MOU with DVHA in 2014. The distributed storage model created several significant barriers to operation. There was insufficient infrastructure in place to continue operations. In order to successfully carry out the project, mechanisms must exist to transport and store equipment, assess the items for safety and function, appropriately sanitize the equipment, and match it to recipients. Although the VATP was able to procure funding to support the work, the necessary facilities and service providers were not available to continue operations and meet the indicators of quality.

To effectively carry out Medicaid equipment retrieval and redistribution in Vermont, legislation needs to be implemented. The VATP's experience with the distributed storage model clarified the need for legislative direction. This would allow the state to build the necessary infrastructure, such as multi-stakeholder development of policies, procedures, and oversight; as well as participation of durable medical equipment vendors in transporting, refurbishing, and matching equipment. The VATP and DVHA have begun conversations regarding next steps toward this goal.

OKLAHOMA DURABLE MEDICAL EQUIPMENT REUSE PROGRAM, 2011

In contrast to more than a decade of operation in Kansas, Oklahoma's reuse program began operations in April 2012, which allowed for a six-month startup period during the first year of programmatic operation. The Oklahoma Health Care Authority (Medicaid) was legislatively mandated to develop and implement a DME retrieval program. After reviewing existing programs, including the Kansas model, the Oklahoma HealthCare Authority (Medicaid) developed a request for proposal for a partner to operate a DME reuse program similar to the Kansas model. ABLE Tech, the state AT Act Program, responded and was awarded the contract. The program was funded in December 2011. Under this plan, DME is appropriately matched, reassigned and delivered to eligible Oklahomans free of charge.

Eligibility. Any Oklahoma resident is eligible with a completed application. The program serves uninsured, under-insured and insured citizens who find the co-pay or deductible too expensive.

Operations. Like Kansas, Oklahoma's Medicaid program pays for inventory tracking of DME retrieved from Medicaid beneficiaries and general donations from other citizens and the repair and refurbishment of equipment for beneficiaries. Contracted DME vendors provide repair services, and in some cases, regional warehouse storage for refurbished equipment. Equipment is reserved for SoonerCare (Medicaid) beneficiaries for 60 days, and then released for distribution to the general public. After 180 days, some items are posted to the Able Tech Exchange Program. Others are provided to the Oklahoma City equipment cache where they are matched to individuals whose DME has been lost, destroyed or is need of repair following a weather-related disaster.

The program began without a statewide distribution network, so it had planned to limit service to the state's two largest cities, Oklahoma City and Tulsa, with delivery service limited to a 50-mile radius of Oklahoma City. The launch of the program created tremendous interest and resulted in alternative transportation options that use vendors and some non-profit entities to access other parts of the state, thereby allowing the program to provide services statewide. The non-profit entities are reimbursed mileage at a reduced rate.

Oklahoma Durable Medical Equipment Reuse Program Initial Years

| Year | Consumer Requests | Donated Devices | Value of Donations | Reassigned Devices | Value of Reassigned Devices |
|--------------------------------|-------------------|-----------------|--------------------|--------------------|-----------------------------|
| Year 1 (April – Sept. 2012) | 120 | 116 | \$68,078 | 116 | \$68,078 |
| Year 2 (2012-13) | 469 | 584 | \$388,569 | 582 | \$363,362 |
| Year 3 (2013-14) | 665 | 708 | \$378,816 | 706 | \$377,078 |
| Total | 1,254 | 1,408 | \$835,463 | 1,404 | \$808,518 |

Source: CATADA

Stan Ruffner, DME Program Director for the Oklahoma HealthCare Authority, is pleased with the success of the program, which he says is a “win/win” without negatives.

Medicaid case management nurses are in contact with the program on a daily basis to identify equipment for beneficiary needs.

Responding to some initial concerns at the outset, the program held town hall meetings with DME providers to explain how the program would work and the opportunities for the providers. He believes the providers are now supportive and benefit from the repair revenue. As noted earlier, those providers have been instrumental in providing transportation and storage support. He also notes that reuse can fill the gaps with some devices that Medicaid does not provide (e.g., adult nebulizers), and that paying a substantial fee to refurbish an expensive power chair still results in a huge savings, or that purchasing new accessories for a donated CPAP machine is an excellent use of funds.²⁰

The Oklahoma program has few Medicaid devices returned to the program, so the majority of the equipment is from public donations. He credits the Able Tech program leadership with community outreach to generate support and donations. Print and TV news stories (which tend to develop about every six months) result in increased donations, and the program sponsors periodic donation drives.

²⁰ Stan Ruffner, conversation with Trish Redmon, 8/18/2015.

VIRGINIA REUSE NETWORK: LIMITED TRIAL TO RECLAIM AND REUSE DME, 2011

The Virginia Reuse Network is a working partnership of the Virginia Assistive Technology System (the AT Act Program), the Department for Aging and Rehabilitative Services, the Foundation for Rehabilitation Equipment and Endowment (FREE), and the Commonwealth Neurotrauma Initiative. As noted earlier, a Medicaid official serves on the Advisory Council for the Reuse Network. FREE Foundation, a pioneer in the reuse of DME starting in 1999, operates the reuse program for the network. Two years ago, at the urging of Vocational Rehabilitation, Medicaid initiated a pilot program with DME vendors in the Roanoke area to place stickers on devices purchased by Medicaid. The stickers urge that the devices be donated if no longer needed. Donated equipment is sanitized and refurbished by FREE and distributed through the statewide Reuse Network. However, as noted in the Kansas and Oklahoma experiences, the rate of equipment return from Medicaid beneficiaries is not high volume.

PARAQUAD CENTER FOR INDEPENDENT LIVING (CIL) REUSE PROGRAM

Another model for engagement with Medicaid is providing repairs and maintenance for durable medical equipment. This is the case with some Centers for Independent Living that engage in reuse programs. One example is Paraquad, Inc., in St. Louis, one of the country's oldest CILs. Paraquad operates an accredited Assistive Technology Program that includes being a recognized supplier of repair services for both manual and complex rehabilitation equipment. Maintenance by certified repair professionals is a major service for clients with disabilities. The income from repair services provides approximately one-fourth of the funding needed to operate the program.

PROPOSED GEORGIA MODEL: NONPROFIT REUSE PROGRAM AND MEDICAID IN MAJOR HOSPITALS

One proposed model for reuse is a partnership with hospitals that would serve Medicaid beneficiaries by providing essential DME upon discharge, perhaps only as an interim solution while awaiting new devices for which they may be eligible. Friends of Disabled Adults and Children (FODAC), the nonprofit reuse partner of Tools for Life, Georgia's AT Act Program has assisted Grady, Atlanta's large public hospital, by providing durable medical equipment for uninsured patients upon discharge and it also works directly with Rockdale Medical Center in Conyers to provide needed equipment for uninsured patients. Neither partnership is a Medicaid program.

E. MEASURING OUTCOMES

The simplest model for measuring success of reuse programs is tracking the growth in number of devices and value of equipment acquired and reassigned and the number of customers served. The reutilization activities of the AT Act Programs are tracked through NISAT and made available to the public through the Center for Assistive Technology Act Data Assistance. Only reuse activities that receive financial assistance through the AT Act are reported, and a significant number of nonprofit and volunteer organizations engage in reuse. Programs were surveyed for voluntary reporting in 2006, but reporting from all AT Act Programs really began in 2008.

Device Reutilization Reported by AT Act Programs

| Year | Exchange Number | Exchange \$ Value | Refurb./ Reassign Devices | Refurb./ Reassign \$ Value | Open-Ended Loans | Loan \$ Value | Total Devices | Total \$ Value |
|-------------------|-----------------|-------------------|---------------------------|----------------------------|------------------|---------------|---------------|----------------|
| 2008 ¹ | 1,312 | 3,365,398 | 22,738 | 11,553,160 | 6,019 | 2,414,725 | 30,069 | 17,333,283 |
| 2009 | 1,450 | 3,559,476 | 26,936 | 12,236,872 | 6,343 | 1,432,431 | 34,729 | 17,228,779 |
| 2010 | 1,331 | 2,826,996 | 28,389 | 13,355,432 | 6,124 | 1,795,618 | 35,844 | 17,978,046 |
| 2011 | 1,564 | 2,474,173 | 30,928 | 12,745,444 | 7,501 | 2,110,916 | 39,993 | 17,330,533 |
| 2012 | 2,100 | 3,315,152 | 28,740 | 11,339,569 | 19,483 | 5,198,708 | 50,323 | 19,853,429 |
| 2013 | 3,206 | 3,315,152 | 37,877 | 14,618,227 | 8,422 | 3,013,585 | 56,588 | 20,946,964 |
| 2014 | 3,428 | 2,917,564 | 43,693 | 18,129,877 | 10,624 | 4,214,568 | 57,745 | 25,172,009 |

¹ First year of full reporting for reutilization activities.

² Center for Assistive Technology Act Data Assistance (CATADA). (2015). <http://www.catada.info>.

Using this form of outcome measurement, the program is evaluated based on how many customers are served and how much money is saved based on some comparison to the retail cost of equipment. While this provides an interesting gauge, it does not measure several variables: the cost of lost income for the person in need of durable medical equipment, or lost education time for a student, the cost of providing care to the individual, or the cost of additional medical care that may be incurred in the absence of needed durable medical equipment. It also ignores the value of avoided environmental costs when equipment is kept from landfills.

While volume and value tracking are important, more sophisticated and complex measures of the value of reuse activities have been developed and shared.

ANALYSIS OF RETURN ON INVESTMENT FOR AT REUSE

Dr. Sara Sack, National Task Force member and director of the Kansas AT Program, initiated the application of a common business measure, return on investment (ROI), to AT reuse. Originally this involved simply using the valuation of the donated AT devices and the cost of program operations to compute the return. This was sufficient to win the approbation of a Kansas legislator when early analysis showed a return of \$2.62 for every dollar spent. Later, she refined the use of return on investment for use as a decision-making tool, demonstrating that a collection drive for lightly-used, high value devices or

bariatric equipment resulted in a greatly increased ROI (\$8.39 for every dollar spent) when compared to using resources to acquire generally available durable medical equipment.

To “value” donations for use in ROI equations and savings related to reuse, it is recommended used equipment be valued at 75% of the manufacturer’s suggested retail price. That is what Medicare will pay for used equipment. Also, in the ROI equation, all new costs related to reuse needs to be considered, such as pick-up, tracking, cleaning, repairs, etc.

EXAMINING USER OUTCOMES

Some of the earliest research on reuse outcomes was conducted by Washington University and Carla Walker, Kerri Morgan and Lindsey Bean of Paraquad’s AT Reuse Program in St. Louis. This research addressed the outcomes experienced by recipients of mobility devices, shower benches and raised toilet seats or commodes. The data collection instrument surveyed outcomes by domains of participation. Paraquad subsequently incorporated a modified version of the outcomes survey into its standard practices. That survey instrument and the methodology were shared in a Pass It On Center webinar and are included in the Knowledge Base.²¹

INCLUDING AVOIDED COSTS IN THE VALUATION OF REUSE

While Paraquad surveyed actual outcomes, the Foundation for Rehabilitation Equipment and Endowment (FREE) of Virginia, a reuse partner in the Virginia Assistive Technology System (VATS), devised measures to value the avoided outcomes resulting from AT reuse. FREE’s questionnaire was designed to determine whether the user became more independent, had fewer falls, reduced visits to doctors or emergency rooms, reduced the length of hospital stays, or were able to remain in his/her current residence without requiring a higher level of care. FREE identified the cost of those negative outcomes to quantify the value of avoided costs. For every 100 persons served, it identified \$465,586 in avoided costs.²² Kansas also collected data on the use of \$180,000 with 1,000 people, of whom 12 reported that the program kept them out of an institution or got them out of one.

Building on earlier efforts, the Pass It On Center proposed a more comprehensive calculation of the value of AT reutilization (tentatively dubbed a Calculation of the Approximate Value of Investment in AT Reuse or CAVIAR) that incorporates the value of

²¹ *Measuring AT Reuse Outcomes at Paraquad*. User Services Module, Pass It On Center Knowledge Base at <http://www.passitoncenter.org/content>.

²² For more information, see March 2011 webinar, *Making the Business Case for AT Reuse*, in the webinar archive at www.passitoncenter.org.)

equipment, the value of prevention, environmental impact savings and the economic value of work. When Kansas used very conservative assumptions to include some of the avoided costs, it increased overall ROI from \$2.62 to \$3.11.²³

Even this proposed calculation does not attempt to value improved function, the ability to work or attend school, the capacity to care for one's self or family, or the effects of depression and isolation that may result from mobility limitations. Some research has been done on the effects of depression and isolation, but not on avoided outcomes.

There is a need for additional research to understand the relationship and the availability of appropriate, lightly used DME as part of a strategy to prevent falls or secondary injuries. Indeed, such research might impact the provision of more DME, whether new or reused, to help contain the resulting medical costs.

There is a significant need for research comparing the outcomes with different devices. Receiving a device over no device at all is certainly important, but receiving the most appropriate device to address medical and functional needs should be the goal. Far too little research has been conducted to assist policy makers and clinicians to determine and identify the appropriate technologies for an individual. The consolidation of billing codes used to group products for reimbursement purposes now has some codes that do not group homogeneous technologies, and yet coverage policies are developed based on these codes. Research that compares features and options to assist in identifying the impact of trade-offs that occur in the technology recommendation process would help payers, clinicians and consumers in determining what will provide the best outcome given an individual's specific needs, activities and routine environments. In order for technology to play an appropriate role in the reduction of health care costs and improved outcomes, more research and more data is needed.

THE POTENTIAL DOWNSIDE OF R E U S E

Widespread reutilization of DME has the potential for unintended negative costs as well, including the possibility of a decrease in innovation. If a market is not large enough to support product design and development, manufacturers will further reduce these efforts. Also, fewer new units sold, combined with multiple years of decline in reimbursement, is reducing innovation and the number of options and configurations (especially for mobility equipment) that can be supported by manufacturers. This is particularly problematic for manufacturers of complex rehabilitation technology because the market size is small. Unique items with very small populations of people that need them will be the first group to be impacted. The result will be fewer options and higher costs for the options that remain available.

²³ Ibid.

F. ADMINISTRATIVE AND OPERATIONAL ISSUES

Governmental and nonprofit reuse partnerships face challenges similar to commercial businesses. They must comply with legal and regulatory issues related to the equipment, the workplace, and the management of employees. Most reuse programs are heavily dependent on volunteers, and that presents additional challenges for training and consistency of task performance. Sustainability is an ever-present concern, and Medicaid partnerships may provide increased stability for AT reuse programs while realizing a significant return on the investment of taxpayer dollars.

The Indicators of Quality for AT Reuse (IQ-ATR), developed with national input and broad review, were released in September 2009. They address the administrative and operational issues faced by AT reuse programs. The following sections reference the Indicators of Quality that apply to Medicaid partnerships. The complete report and the Online Program Assessment Tool can be found at the [Pass It On Center](#). Each indicator includes a rationale and a set of Key Factors for Consideration. The purpose of the assessment is to highlight areas that need improvement and to provide resources to support change.

Program leaders must have the knowledge, skills and experience specific to their assigned roles. (*IQ-ATR 5.1 - Management Expertise*)

A start-up program will benefit from the inclusion of at least one key program leader with broad knowledge of durable medical equipment. Chief issues related to the reuse of AT devices include the potential liability related to safety of the equipment for reuse, possible transmission of disease, and the use of volunteers to perform key tasks.

Specific strategies recommended for risk mitigation include implementation of policies and procedures related to sanitization of devices, tracking of devices for recalls, and the use of waivers of liability when transferring ownership of devices. (*IQ-ATR 5.3 - Risk and Liability Management*)

LEGAL/COMPLIANCE

Reuse programs are subject to employment, workplace, health and environmental laws. In addition, the program must maintain its records within the provisions of its legal (or tax) status and all applicable laws. (*IQ-ATR 5.4 - Recordkeeping*)

LIABILITY AND DEVICE SAFETY

Reuse programs can mitigate risk by following some recommended practices. These include: (1) informing consumers that the devices are used and clarifying what warranties, if any, are offered with the equipment; (2) involving professionals in the matching of appropriate equipment; (3) demonstrating safe and appropriate use of the equipment for the new user and making user manuals available if possible; and (4) maintaining a system for notifying the new user if warnings or recalls are issued for the device. These are addressed in detail in the User Services section below.

Policies and procedures for all aspects of operations are essential to safe operations. This requires ongoing education, training and supervision to ensure compliance with the policies and procedures.

Reuse programs must assure safety and sanitization practices for the workers who clean and refurbish and for the next user of the reclaimed equipment. This subject received significant attention in the education and training resources provided by the Pass It On Center. The suggested sanitization practices are consistent with the recommendations of CDC. These issues are included in the Indicators of Quality for AT Reuse.

The safety of users of refurbished equipment requires the ability to track the assignment of specific devices to notify recipients of consumer warning or recalls, whether issued by the Food and Drug Administration (FDA), the manufacturer, or the Consumer Product Safety Commission. Regulatory compliance also includes requiring prescriptions for devices that require prescriptions under normal circumstances, following state laws related to device setup by specific healthcare professionals, and training staff in patient privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA).

Programs should establish policies related to the age and/or condition of devices deemed acceptable for reuse. In promoting equipment donations, it is important to inform the public of the types of devices that will be accepted, required condition and age limitations. Age is not always the most significant indicator of acceptable condition, but it is important. Tests by RESNA were based on assumptions of an average life expectancy of five years for wheelchairs. The target should be lightly used devices and the program should adhere to carefully established evaluation criteria.

If recovery of a high percentage of Medicaid purchased equipment is the goal, the program (Medicaid) may want to retain ownership. If Medicaid retains ownership, the item can be tracked and the beneficiary can be contacted to determine if the equipment is still being used. Some reuse programs transfer ownership of the refurbished device to the new consumer/beneficiary with a request (and sometimes a sticker with information) that the device be returned when no longer needed. The consumer accepts the sanitized, refurbished device 'as is' and signs a release from liability. Some programs warranty devices for a limited period of time, providing repairs as needed during the warranty period.

FINANCIAL

Medicaid programs receive both federal and state funds (see Section II.) All Assistive Technology Act programs receive some federal funding; some also receive state support. The reuse component of the program often involves partnerships with nonprofit organizations committed to reuse, centers for independent living, or other organizations that serve people with disabilities. The partnership often helps to defray the cost of operations through shared facilities, staff or overhead costs. Some programs leverage the cost of sanitization and device refurbishing to generate earned revenue. For example, they may offer repairs by certified technicians or offer inexpensive manual wheelchair cleaning in a commercial-grade automated device in which several manual wheelchairs can be sanitized simultaneously. The repair service at Paraquad in St. Louis generates revenue to cover about one-fourth of the cost of the reuse program.

Nonprofit reuse programs may receive additional support in the form of grants from one or more sources. Some programs have reported receiving funding for diverting equipment from local landfills. The challenge becomes maintaining a stable stream of revenue to sustain the program.

Reuse programs vary significantly in size and therefore budgets. After surveying exchange and reassignment reuse programs in 2008-2009, Dr. Sara Sack defined a sizing model based on the number of devices exchanged or reassigned in a year. No programs in the sample fit in the X-Large category. These survey respondents were not all Medicaid partnerships, and these are annual expenses, not start-up program costs.

Annual Expenses for Reuse Programs by Devices Reused per Year ²⁴

| Expense Category | Small 1-50 | Medium 51-199 | Large 200-499 | X-Large 500-999 | XXX-Large 2000+ |
|-----------------------------|------------|---------------|-----------------|-----------------|--------------------------|
| Personnel | \$40,000 | \$70,000 | \$80,000 | NA | \$140,000 |
| Travel In State | \$500 | \$500 | \$1,000 – 2,000 | NA | \$3,000 |
| Project Supplies | \$200 | \$500 | \$1,000 | NA | \$1,500 |
| Web Site Hosting | \$900 | \$500-5,000 | \$500 | NA | NA |
| Phone | \$500 | \$500 | \$1,000-1,500 | NA | \$1,500 |
| Printing | \$500 | \$500 | \$500-750 | NA | Included in PR/Marketing |
| Marketing/ Public Relations | \$200 | \$0 | \$4,650 | NA | \$2,500 |
| Equipment Shipping/Pickup | \$100 | \$1,500 | \$1,000 | NA | \$2,000 |
| Refurbishment Supplies | \$0 | \$20,000 | Not reported | NA | \$42,000 |

Based on research by Sara Sack, University of Kansas

²⁴ Sack, Sara. *Budgeting Session, Creating or Improving Your AT Reuse Program Pre-Conference*. Assistive Technology Industry Association Conference, Orlando, 2009.

The issue of funding a reuse program that includes Medicaid is one of identifying the intersection of need and services, then defining a sustainable model. Start-up budgeting is addressed in Section 6 – Implementing a Reuse Partnership.

Programs with technicians for refurbishing reported an average of \$45,000 for salary and fringe benefits. Rents, if applicable, ranged from \$4,500 to \$20,000 annually.

Transportation is a common issue for reuse programs that rarely have adequate budgets to support enough vehicles for pickup of donation and delivery of equipment. It is another area that often depends on partnering with other organizations.

PROGRAM OPERATIONS

The Indicators of Quality for AT Reuse developed in 2009 address all areas of Program Operations. They are cited in appropriate sections to describe the expected practices.

PARTNERSHIPS: AGREEMENTS, ROLES, RESPONSIBILITIES

The contract between Medicaid and the AT reuse program will specify roles and responsibilities. These will be clearly defined.

EQUIPMENT TRACKING

The program should have written policies and procedures and an accurate and efficient method to track the inventory of available devices that includes:

- Unique identification of every donated device (by paper label or bar code)
- The ability to determine the availability of devices by type
- The assignment of an inventory valuation to each device (often based on a percentage of the manufacturer's suggested retail price)
- The frequency, scope, and cost of previous repairs to determine if future repairs should be approved or if the item should be eliminated from the inventory
- The ability to identify devices subject to recall notices
- The ability to identify customers who have received devices subject to recalls, market withdrawals or safety alerts

(IQ-ATR 3.4 - Device Tracking, IQ-ATR 3.5 - Device Valuation and IQ-ATR 3.6 - Management of Device Recalls, Market Withdrawals and Safety Alerts)

The inventory system should be capable of capturing detailed specifications for equipment (e.g., manufacturer, model number, serial number, seat height, seat depth, weight limit for a manual wheelchair). This data facilitates the identification of appropriate equipment for specific needs.

The program may formulate policies related to priority holds or wait-listing for the Medicaid program or other participants.

Appropriate disposal of devices that have no more useful life can present a challenge to the reuse center, especially if those devices are electronic and/or digital. The components of many electronic devices are potential hazards to the environment if not disposed properly.

When a device has no more useful life, disposal of the device must be done in a manner consistent with environmental regulations. Reuse programs should identify certified recycling resources. *(IQ-ATR 3.17 - End-of-life Recycling)*

SANITIZATION

When devices are acquired by an assistive technology reutilization center, one of the first priorities is to make those devices safe for use by other individuals. Steps should be taken immediately to minimize the potential transmission of disease. The best way to protect all individuals who will come into contact with reutilized equipment is to institute sanitization practices that make the objects safe to handle and to use. The recommended practices are based on manufacturer recommendations, guidelines from the CDC and the practical experiences of reuse programs in implementing these recommendations. *(IQ-ATR 3.10 - Sanitization of Donated Equipment)*

REFURBISHING, REPAIRING AND STORING DONATED DEVICES

The program has written, device-specific procedures that are applied consistently for evaluating the repair and refurbishing needs of donated equipment *(IQ-ATR 3.9 - Evaluation of Used Devices)*. Once identified, the refurbishment/repair of equipment must be performed in a manner that is consistent with manufacturer instructions and original specifications *(IQ-ATR 3.11 - Refurbishing Donated Equipment)*.

Programs offer a limited warranty on refurbished devices, often a 30-day warranty with a commitment to repair or replace the device if necessary *(IQ-ATR 3.14 - Limited Warranty for Refurbished Devices)*.

Appropriate storage facilities are essential to separate sanitized from unsanitized equipment; to organize storage of different types of devices; and to provide proper heating, cooling and ventilation as needed *(IQ-ATR 3.15 - Storage of Donated Equipment)*.

TRANSPORTATION

Procedures and training are essential for picking up donated equipment or delivering refurbished devices *(IQ-ATR 3.16 - Transportation of Donated Equipment)*.

USER SERVICES

User Services address the intake of the consumer at point of application for services, and interactions and services from the time the consumer is assigned a piece of equipment.

PATIENT INFORMATION PRIVACY COMPLIANCE (HIPAA)

As noted above, program staff should be trained in the privacy provisions of HIPAA.

INTAKE AND ELIGIBILITY PROCESS

Customer or patient intake may result from referral by a physician, hospital or other professional resource, or it may be the result of self-referral. Each program specifies eligibility requirements. The application for services should gather sufficient detail to determine eligibility (*IQ-ATR 4.1 - Customer Intake*).

PRESCRIPTION REQUIREMENTS AND MATCHING DEVICES TO CUSTOMER

As noted earlier, the reuse program should adhere to all prescription requirements. Appropriate device reuse for some categories requires appropriate matching of devices to customers based on medical prescriptions and the services of professionals (e.g., occupational therapists or other AT professionals) (*IQ-ATR 4.2 - Matching Device to Customer*).

The customer and direct support provider(s) are informed of all appropriate device options and are allowed to participate in the choice of device (*IQ-ATR 4.3 - Customer Choice*).

The customer and his direct support provider(s) are given basic training on features, operation, maintenance, safety and troubleshooting for the device at the time the device is reassigned (*IQ-ATR 4.4 - Customer Training on Device*). The customer is given a trial period with the device (*IQ-ATR 4.5 - Customer Trial on Device*).

If the customer is unable to pick up the equipment, it may be delivered by trained staff. Some programs have limited transportation alternatives (*IQ-ATR 4.7 - Equipment Delivery to Customer, IQ-ATR 4.8 - Trained Delivery Staff*).

If a new user experiences difficulty, he or she should be able to call for and receive technical assistance (*IQ-ATR 4.6 - Technical Assistance*).

Programs should establish a follow-up protocol to ensure that the needed devices are being used and that the customer has not encountered difficulty (*IQ-ATR 4.9 - Customer Follow-up*).

G. LESSONS LEARNED ABOUT IMPLEMENTING PARTNERSHIPS

What are the goals for implementing a durable medical equipment reutilization program within Medicaid? Usually, the primary goal is to optimize the use of the Medicaid funds through safe and appropriate reuse of lightly-used durable medical equipment. It is expected that the program will save money in the aggregate after the start-up period. The reuse program implementation plan must address the provision of new versus used equipment if the reuse program is to be sustainable and if consumers' needs are to be met.

Implementation of managed care in some states appears to have resulted in an increased focus by care coordinators on locating used equipment in an effort to reduce program expenditures. Reuse programs have been very successful in presenting lightly used equipment as one option if the needed device is available, not the only option. To date no program has advocated (and the Pass It On Center does not support) the removal of consumer choice.

Another primary consideration is the inclusion of commercial suppliers. The intent is not to take away from suppliers, but to preserve a role for everyone.

HOW TO GET STARTED

Before starting a program, it is essential to identify legal barriers to reuse under existing laws or Medicaid program regulations. Change sometimes requires legislative action or regulatory changes within an agency. If changes are needed, it may be possible to secure the commitment for change and proceed with planning while those changes are implemented.

CONVENE A WORK GROUP OF KEY STAKEHOLDERS

Identify the populations that are served through the Medicaid program. The extent of eligibility varies by state; some coverage is mandated. Having done this, it will be possible to identify agencies, organizations, and individuals who serve those populations and might be affected by a reuse program. Including representatives from all stakeholders increases the opportunities for a successful program launch. This group typically includes representatives from:

- Medicaid program
- Assistive Technology Act Program
- A representative of the Pass It on Center with expertise in Medicaid and Reuse Initiatives
- Independent Living Council
- Agencies on Aging

- Commercial DME suppliers and/or a representative from the state association of medical equipment suppliers
- Nonprofit suppliers of DME or related services in your state (often Goodwill, Easter Seals, United Cerebral Palsy, or faith-based organizations)
- Advocacy groups for people with disabilities

This group could include representatives from other government agencies that purchase DME, with the goal of gaining support for reclaiming equipment that is no longer needed. In Virginia, for example, the Brain Injury Trust Fund and the Veterans Administration also sticker newly-purchased devices for return to the reuse program. It could also include representatives from hospitals that serve large numbers of Medicaid patients, with the goal of assigned needed DME as soon as possible upon or after discharge. This strategy optimizes recovery (or at least best outcomes) and impacts the Medicaid budget by avoiding return visits to doctors, emergency rooms and hospitals.

An initial step should be acquainting the group with successful models of reuse in Medicaid. The Pass It On Center can provide information and presentations, or the group can invite a representative from an existing Medicaid reuse program.

DEFINE SCOPE OF SERVICES

A review of existing models can aid the identification of desirable activities and characteristics for the proposed program. The Pass It On Center is a useful resource for implementation resources. The August 2012 webinar on Medicaid is a good starting point for discussions. The slides and audio are available in the webinar archive (accessible from the PIOC website home page.²⁵) The Knowledge Base contains a broad range of information for the operation of a reuse program including a guide to developing a business plan and a three-year financial plan. It also includes an example of a Request for Proposal.

The workgroup will need to define the scope of services to be offered. This includes specification of devices or equipment that will be accepted for refurbishing and reassignment. The program may want to limit reuse to devices or categories that represent the greatest return on investment. Bariatric equipment and sleep apnea devices are expensive and in great demand, for example.

There are other considerations. A refurbishing program may elect to limit devices to specific manufacturers. For example, if wheelchairs are accepted only from two or three major manufacturers, technicians will be trained for those and repairs can be made more

²⁵ *Medicaid: A Look at Reuse in Current Programs*. (August 2012) Pass It On Center. Available at <http://www.passitoncenter.org/webinars.aspx>

efficiently. Doing so could also limit the range of spare parts needed. As noted earlier, highly customized devices may be less appropriate for reuse for many reasons.

The group should also address supporting services that will be offered. These could include assessment for appropriate equipment (which requires appropriate professionals), matching to appropriate devices (also sometimes requiring professionals such as occupational or physical therapists), and maintenance and repair of the assigned devices. (Some state laws mandate assessment or fitting of specific devices by healthcare professionals with specific credentials. Again, state law is very important in program design.)

Optimizing processes and procedures will contribute to financial outcomes. For example, Friends of Disabled Adults and Children, a nonprofit reuse program in Metro Atlanta, adopted a “value stream” production system to streamline program operations.

It will be easier to identify participating organizations or individuals and their potential roles in the program after the proposed operating model has been defined. This model should consider device acquisition strategies, safeguards from liability, eligibility, priorities for inventory usage, and a distribution strategy.

Medicaid covers the entire state, so decisions must be made about how to serve different geographic areas. Reuse programs frequently encounter the issue of transportation for device delivery. Programs often create a network using existing agency resources, volunteers from organizations in the network, or contractual arrangements with commercial suppliers.

ADDRESS LIABILITY CONCERNS AND PROGRAM OPERATIONS

All programs face two areas of liability concern: issues of organization structure, governance, insurance and human resources, and issues related to reuse program operations. Compliance with all prevailing laws and regulations is critical. This includes compliance with provisions of the Food, Drug and Cosmetic Act (FDA) that apply to some devices, especially the ability to identify the recipient of a specific device to respond to alerts and recalls. Programs also need to require prescriptions for those devices that would require prescriptions for acquisitions from commercial suppliers.

Liability arising from program operations can be mitigated by implementing policies, procedures and training that are consistent with the Indicators of Quality for AT Reuse (see <http://www.passitoncenter.org>).

Programs should have a protocol in place to ensure that the donor owns the equipment or has the right to donate it. This avoids having items donated that remain the property of some other agency or entity or that were stolen. Other forms of liability are mitigated by having standards for age and condition of donated devices, having the devices repaired and refurbished by qualified technicians, using appropriate replacement parts, and sanitizing the devices properly for the safety of workers and recipients.

Liability follows ownership. In most reuse programs, the reuse program assumes ownership of the donated device, whether purchased by Medicaid or another party. The device is sanitized, repaired and refurbished as needed, then reassigned to a new user who accepts ownership and signs a release from liability.

Intake procedures must include a determination of eligibility based on regulatory or agreed-upon guidelines. HIPAA compliance is essential. Medicaid must determine if it will reserve the right to place priority holds on inventory items, and if so, for how long. The reuse program must determine how long it will hold items in inventory. This could vary by category of device and by available storage space.

Where needed or required by law, appropriate professionals (e.g., physical therapist, occupational therapist or respiratory therapist) should match devices to beneficiary needs. The correct fit or adjustment is a critical factor in acceptance and use of AT.

Liability can take the form of injury or property damage. In over 10 years of operation, the Kansas reuse program has experienced only four incidents that *could have* resulted in liability issues. A back injury by a staff member, an overturned power chair and a hospital bed collapse were addressed with staff training and clarification of practices. In the fourth incident, gouged vinyl flooring in the customer's home was replaced.

Customer follow-up helps to ensure that the device is appropriate, acceptable and being used.

Programs need to be prepared to dispose of devices that have no more useful life, either through cannibalization for useful parts or environmentally safe disposal by using certified companies for disposal. Reuse programs are cautioned against altering devices from the original manufacturer specifications (remanufacturing) as a serious potential liability. All repair and refurbishing should be consistent with the original manufacturer's specifications.

PREPARE A PROJECT PLAN AND PRELIMINARY BUDGET

The Pass It On Center includes a preliminary project plan among its resources²⁶, but it might prove useful to review the experience of recently implemented programs. Every project is different because the state, the Medicaid program, and the issues vary.

The Medicaid program will need to develop a budget for the agreed-upon activities. For example, in Kansas this includes supporting the database and tracking expenses for all

²⁶ *Business and Strategic Plans*. (July 11, 2011) Pass It On Center. See sample plans attached to article in Organization Module of the [Knowledge Base](#).

reutilized equipment and compensating suppliers for repairs for those devices reassigned to Medicaid beneficiaries. It might include expense allocations for the use of professionals for other specific activities, and for the pickup or delivery of equipment.

The budget would be based on assumptions about the number of individuals to be served. Again, recent experience in other programs might offer useful data.

In most states, the Medicaid program would need to prepare a request for proposal (RFP) to contract services with other suppliers for the reutilization services. The Oklahoma RFP is available in the Pass It On Center Knowledge Base. Responses to the RFP would be reviewed to identify the reuse partner.

Funding the program is a key concern, and budgeting should be realistic. It may not be practical to expect a return during Year One, but significant benefits should be realized after the program is in place. The acceptance of the program will depend on how well it is explained to prospective beneficiaries.

For start-up budgeting, Dr. Sara Sack, Director of the Kansas Equipment Exchange recommends that Year One and perhaps Year Two assume that the program will be “cost neutral,” that is, that significant savings may not be realized for the first two years. In commercial terms, this would be planning for break-even operations before profitability.

The program will first need to determine how it will operate and the level of funding needed to support the infrastructure. It will take some time to establish a reassignment network – that is a network of organizations that provide intake, eligibility, matching and distribution services. It will also take some time to build a working inventory from donated devices to have the appropriate equipment to reassign. Once the program is established and the public becomes aware of the need and the services, circumstances change rapidly. For example, Oklahoma experienced a rapid expansion in supporters and voluntary partners shortly after start-up as other agencies and organizations working with people with disabilities recognized the value of the reuse program. At that point, equipment purchased by sources other than Medicaid (insurance, private pay, etc.) is being donated and some Medicaid-purchased equipment is being recovered. When this point is reached, a return of one to two dollars for every dollar spent is probably a safe assumption. The return on investment could be much higher, but this depends on the inventory and distribution model. Each program must analyze the decisions made about the operational model for budgeting assumptions.

DETERMINE HOW PROGRAM WILL BE FUNDED

There are many models for reuse partnerships, and they should be examined to determine which, if any, are appropriate for the circumstances in a given state. Medicaid can analyze which items or categories of devices represent the greatest potential for successful reuse.

The Medicaid durable medical equipment budget should not be used to start a reuse partnership. The program start-up costs should be budgeted separately. Otherwise, neither funding for new devices nor appropriate used devices might be available for beneficiaries. It is important to build a viable reuse program with an inventory of devices appropriate to the population before assuming the availability of lightly-used devices in the budgeting process.

In some states, the reuse program uses Medicaid funds to refurbish equipment for Medicaid beneficiaries. The refurbishing may be done by a separate reuse facility or by commercial suppliers that partner with Medicaid. In other states, DME refurbishing suppliers offer repair services for Medicaid and the public, and submit the request for reimbursement for Medicaid beneficiaries directly to Medicaid. Medicaid may pay the cost of inventory management for all used devices recovered in exchange for priority claim on devices. Medicaid could identify a specific category (or categories) of devices that it deems more practical or beneficial for reuse.

IDENTIFY DESIRED RETURN ON INVESTMENT

Each Medicaid program should consider the categories of devices that result in the greatest expenditures and weigh how reuse might impact those categories. This would include consideration of devices that are more generally short-term use and more likely to be recovered or donated to the reuse program. It could be a consideration for a category that is particularly expensive, such as bariatric devices.

In addition to the value of equipment (and money saved), there are other factors that can be included in the calculation of return on investment:

1. Avoided falls and the resulting consequences (physician visit, emergency room visit, nursing home stay, or hospital stay),
2. Increased independence in employment, education, recreation and everyday activities,
3. Prevention of lost earnings by the user, relatives or other caregivers, and
4. Savings from avoided landfill costs related to discarded DME that has a remaining useful life. (See Appendix III.)

DONATION AND REASSIGNMENT SAFEGUARDS

A first step in safeguarding donations is to ensure that a prospective donor has the right to donate the equipment to the reuse program. Some DME is purchased by organizations that retain ownership and would expect the device to be returned if no longer needed. While reuse programs do not purchase devices (so there is no incentive to donate stolen property), it is still advisable to have policies for ascertaining the right of the donor to give the equipment (*IQ-ATR 3.8 - Donated Equipment: Confirmation of Donor's Ownership*).

Reassignment can be safeguarded to ensure that the devices are not being obtained for resale. Appropriate application and intake policies should collect information about the intended user, and that user should be appropriately matched and trained in the device use. This should result in personal interaction with the device recipient.

DEFINE REIMBURSEMENT MODELS FOR DME SUPPLIERS

In most Medicaid partnerships, DME devices are not sold. However, if approved by change of law or policies, devices could be refurbished by certified suppliers and purchased by Medicaid for reassignment to beneficiaries. Services, such as device repairs either before or after the device is received, may be reimbursed by Medicaid. In these cases, the program will define qualifications for suppliers. In some cases, the suppliers are commercial DME suppliers with certified technicians. In others, the supplier may be a reuse program with appropriately trained technicians.

EXPLAIN THE ROLE OF REUSE TO BENEFICIARIES

The program will need a public awareness campaign to explain key facets of the reuse program:

- Why used versus new
- What makes this safe and effective
- Who owns the equipment, implications for consumers
- How the beneficiary gets equipment repaired
- Stories from actual users

This information can be disseminated through the network of partners and associated organizations and through the use of public media.

A TIMELINE FOR IMPLEMENTATION

The Oklahoma Durable Medical Equipment Reuse Program was launched officially in December of 2011 with the award of a contract to ABLE Tech, the Oklahoma Assistive Technology Act Program. This was the culmination of a long journey described in the timeline below. The actual launch was accomplished in a compressed timeframe once the decision to proceed was made. Circumstances vary in each state, so it is impossible to predict how long it might take to remove legal and administrative barrier, to organize interested parties, and to create an operational reuse program with Medicaid. At the most optimistic, this timeline might be compressed to 12-18 months by using the experience of existing programs and the resources provided by the Pass It on Center.

Key Events in Establishment of Oklahoma Durable Medical Equipment Reuse Program

| Year | Activity |
|------|---|
| 1999 | Medicaid changed its policy from individual ownership of devices purchased with Medicaid funds to one that permitted the state to retain ownership. |
| 2008 | A state legislative task force put language into law to implement a retrieval program as part of the Olmstead Act Task Force. This was to be implemented by 2010, but no funds were budgeted to start the program. |
| 2009 | <ul style="list-style-type: none"> ▪ Stan Ruffner became Director of Durable Medical Equipment at OHCA. ▪ Oklahoma had five representatives at the National AT Reuse Conference: Linda Jaco, Milissa Gofourth and Diana Sargent from Oklahoma ABLE Tech, Stan Ruffner from the OHCA, and Allison Vanden from Acts of Kindness. ▪ The Oklahoma Health Care Authority (OHCA) released a request for information (RFI) regarding DME reuse. |
| 2011 | <p>August – OHCA released a request for proposal (RFP) for a reuse partner.</p> <p>December – ABLE Tech awarded the contract.</p> |
| 2012 | Reuse program opened for business with funding to provide pickup and delivery services only for the area within a 50-mile perimeter of Oklahoma City. Major interest and cooperation quickly escalated and expanded the reach of the program throughout the state. |

APPENDICES

I: RESOURCES

II: CATADA DEVICE CLASSIFICATION SYSTEM

III: CAVIAR – A RETURN ON INVESTMENT CALCULATION

Documents

The resource documents are too many and too large to include in the report, but are readily available in the Pass It On Center (PIOC) [Knowledge Base](#) under the title, “AT Reuse in Medicaid.” These include:

AT Act Programs: Reuse Activities by State

Benefits of the Kansas Equipment Exchange Program

Categories of Equipment for AT Reuse

Frequently Asked Questions (about starting Medicaid partnerships)

Medicaid Transformation Process, A Report of the Kansas Health Policy Authority, 2009, Chapters 1 and 4 referencing reuse of durable medical equipment (DME.)

Oklahoma Medicaid Request for Proposal for Reuse Contractor

Oklahoma DME Reuse Program Operational Manual

Oklahoma DME Reuse Program – Customer Application Packet

Oklahoma DME Reuse Program – Fact Sheet

Provider Report from Kansas Equipment Exchange (example)

Pass It On Center Webinars of Specific Interest for Medicaid Partnerships (see [Webinar Archive](#))

Education, Training and Certifications, July 2013

Expanding Reuse through Public and Private Partnerships, August 2011

Innovative Strategies to Engage DME Suppliers in AT Reuse: How Everyone Can Benefit, December 2012

Lessons Learned from the 12 AT Demonstration Projects: Outcomes, December 2011

Making the Business Case for AT Reuse, March 2011

Medicaid: A Look at Reuse in Current Programs, August 2012

Planning a Sanitization Program, July 2010

Other Pass It On Center resources include:

Knowledge Base

This collection of supporting information for AT reuse programs includes PIOC-authored articles and content donated from reuse programs around the country, many with accompanying fact sheets, brochures, examples, models or checklists.

Indicators of Quality for AT Reuse (IQ-ATR)

Developed by a national work group in 2009, this document identifies factors for consideration in every critical area of operations for an AT Reuse program.

Online Program Assessment Tool (IQ-ATR)

This online tool was developed to support use of the IQ-ATR. Users may assess a program by checking compliance with the Factors for Consideration. The tool generates a report of resources to improve those Indicators that were not fully met.

Webinar Archive

All webinars presented by the Pass It On Center through August 2013 are archived and freely available from the Webinar Archive.

Reuse Locations Database

Reuse programs create profiles for voluntary participation. Users can locate programs by location or type of equipment.

Virtual Tours of Reuse Programs

The Pass It On Center's You Tube channel hosts a collection of more than 100 videos filmed at reuse programs around the country. The segments include interviews with program leaders, interviews with reuse customers, narratives about the program, and details about specific areas of program operations.

APPENDIX II: CATADA DEVICE CLASSIFICATION SYSTEM

The following taxonomy of assistive technology devices is used by the state AT Act Programs when providing data for the Center for Assistive Technology Act Data Assistance (CATADA). There are other ways to classify and categorize devices (e.g., the 20 categories used by the Able Data database).

Devices are assigned to one of the following 10 categories for reporting reuse activity:

1. Speech communication
2. Vision
3. Hearing
4. Computers and related
5. Daily living
6. Learning, cognition, and developmental
7. Environmental adaptations
8. Mobility, seating, and positioning
9. Vehicle modification and transportation
10. Recreation, sports, and leisure

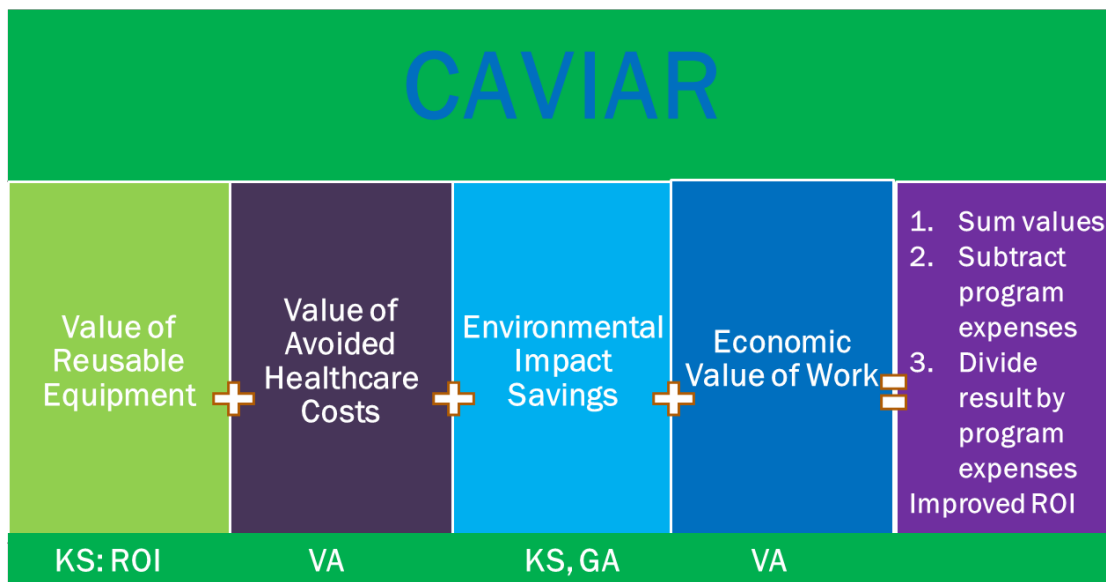
Many devices can fit into more than one category depending on how they are used by a consumer. Devices can most reliably be classified based on the functional need that is served by the “assistive” aspect of the device. For example, a computer that is outfitted with an external speech synthesizer and used as a communication device for a person who had a stroke would be classified as “speech communication”, not “computers and related”.

A component of a larger system should be classified according to the function or primary use of the larger system. For example, a mouth stick that is used to provide access to a communication system such as Pathfinder would be classified under Speech Communication. A mouth stick that is used to type papers would be classified under Computer Access. A mouth stick that is used generically as an aid to daily living would be classified as Daily Living.

APPENDIX III: CAVIAR

Proposed by the Pass It On Center as an alternative measure of the value of reuse, the Calculation of the Approximate Value of Investment in AT Reuse (CAVIAR) extends the computation of Return on Investment beyond the value of equipment to include the societal and economic impact of the availability of assistive technology when it is needed. This model builds on the work of the Kansas Equipment Exchange, The Foundation for Rehabilitation Equipment and Endowment (FREE) in Virginia, and the valuation of recycled end-of-life devices.

Proposed Calculation for Return on Investment of AT Reuse



Appendix III: Business Plan

Executive Summary

FINDME - Facilitating Iowans Needing Durable Medical Equipment. The world in which we live constantly produces waste. One way we handle waste is through recycling. Recycling typically involves the base reduction of waste in to reusable elements or scrap. Another way to recycle is through refurbishment. All pawn shops, consignment stores, Goodwill -type stores, and antique shops participate in refurbishment. In these stores you'll often find attempts to sell durable medical equipment. Things like wheelchairs, walkers, sleep apnea machines and hearing aids all get marked with an "as-is" sign and a price tag far beyond what was actuality paid for the device. Additionally, there's no guarantee or warranty which is typically standard on these device. These devices are rarely sold and often end up being recycled for scrap or tossed in the landfill largely because Iowans do not know or cannot access programs where DME can be refurbished.

Not only do Iowans need an appropriate program to donate DME to avoid the landfill but many Iowans also need access to clean and safe durable medical equipment. Three common scenarios exist for Iowans as barrier to accessing DME.

1. there's a significant delay it ordering or getting insurance approval
2. there's a gap in coverage from health insurance paying
3. the copay/deductible is too high to afford the DME

Our Solution

Definition: Quality used devices are donated, cleaned, sanitized and refurbished, then given away to eligible persons with disabilities.

FINDME staff prioritize helping individuals with disabilities acquire new equipment. Staff work with individuals to review all funding possibilities, but there are times when no funding resources are available or a backup device is needed. In those circumstances, the ability to acquire a quality, refurbished device is an important option.

IPAT provides quality used devices through two efforts. FINDME is a reuse partnership between Iowa Medicaid Enterprise and IPAT. Through FINDME, eligible Iowans can get quality, refurbished durable medical equipment such as manual and power wheelchairs, patient lifts, electronic hospital beds, shower chairs, communication devices and other health devices.

IPAT accepts donations of durable medical equipment for FINDME but other assistive technology devices can be donated to the IPAT reuse program. FINDME partners with local and regional loan closets across the state to help Iowans with disabilities access a wide range of equipment.

Individuals who need used equipment may view the inventory by going to the online database at www.findme.org. Equipment is reassigned on a first come - first serve basis.

Elements of a Quality Reuse Effort

- All Iowans who need assistive technology will have access to high quality used equipment.
- Access to quality equipment can make a tremendous difference in a person's life. Therefore, it's important for everyone to help promote the program and understand the need to locate quality equipment.
- Everyone – vendors, volunteers, colleagues, donors and recipients will be treated with respect.
- Everyone involved with the program should be safe from injury and disease.
 - We believe in:
 - Delivering clean equipment
 - Training staff and volunteers to properly move and set up equipment
 - Involving professionals in the reassignment of certain types of equipment as identified in program guidelines
- The environment should be treated with respect. Equipment that is at the end of its usable life will be disposed of using environmentally responsible methods.

Target Market

FINDME relies on two persistent needs of Iowans; what to do with DME when it's no longer needed and how to get DME in to the hands of people that need it. No matter how well-oiled the insurance or care delivery systems are maintained these two trends will remain true. The current system that attempts to meet this demand lacks a central database of equipment and true state-wide presence.

According to an AARP poll over 42% of Americans over the age of 60 use some type of DME. This demand will become even more consistent as that age demographic gets larger. With more Iowans utilizing DME there will be demand not only for the devices but also demand to effectively get rid of them once they are no longer needed.

Competition

Current Alternatives

In the state of Iowa there are roughly thirty-five different organizations that provide DME refurbishment to varying degrees of professionalism. Most are churches, home health agency (and even one bar) none of which have a manufacturer trained staff providing refurbishment of the equipment. They largely exist as a storehouse with few if any tracking mechanisms. The one agency that does provide trained staff, Easter Seals of Des Moines, has limited capacity to cover the entire state and be reactive to local demands.

Our Advantages

Through strong networking and collaborative efforts FINDME has partnered with Iowa Vocational Rehabilitation Services to provide a refurbishment site at thirteen difference offices throughout the

state. This insures that no lowan has to travel more than 45 miles to drop off or pick up DME through the FINDME program. Often lowans that need DME or want to donate it do not have the resources to do that activity themselves, FINDME provides a transport van at all thirteen of those offices that can pick up and drop off donated DME.

FINDME staff that perform the refurbishment activity are all trained by the manufacturers. This allows a higher quality of DME but also maintains warranties and protects the safety of lowans that use refurbished DME.

Services

Reuse Process

1. Individual contacts the FINDME Site to request a device or to donate a device.
2. FINDME staff completes intake information required on the database personal information tab. Individuals donating devices need to provide basic information on the personal information tab. Individuals requesting devices need to provide all the information on the personal information tab (i.e., basic information, functional limitations, disability causes, funding/benefits).
3. FINDME staff opens a donate or request goal that is assigned to the FINDME staff who has primary responsibility for the program.
 - FINDME staff may assign a request goal to another staff at the site if they have expertise in a unique area of assistive technology relevant to the goal.
4. FINDME staff review the Available Equipment list for a possible match and either arrange for delivery or explain that since the program is based on donations that people sometimes have to wait for an item they need. Assignments are made on a first come, first serve basis.
5. When a match is made, FINDME staff contact the individual to arrange for a time when the individual can pick it up or a home delivery time depending on the individual's needs. Shipping equipment can be an option for some devices.
 - All FINDME staff are expected to help deliver devices if their appointments and delivery schedules coincide.
6. All transactions must be entered in the FINDME database so inventory is tracked.
7. When the device is delivered, reuse outcomes are collected from the individual and entered in the FINDME database.

Market Analysis Summary

Marketing the services of FINDME is the most important aspect of its continued existence. Without lowans knowing where to donate or where to get refurbished DME the program no longer exists. To meet this demand we take a multi-faceted cross-sectional approach to marketing.

1. Local Presence - each of the eighteen sites will have a van with FINDME branding on it. This van will be used throughout the community not only in arranged appointments but will also host monthly collection drives at well-attended community events. Connections with the disability and aging advocacy networks in this communities will allow for group and individual presentations offered by FINDME staff.
2. Online Presence - the FINDME site lists all equipment available throughout the state and can act as a bridge between the user and donor. To ensure visibility the website deploys a variety of search engine optimization tools as well as a strong social media presence.
3. Policy Presence - the FINDME program works closely with advocacy organizations, vendors, hospitals and legislators to ensure DME needs are being met both in collections as well as disbursement. Efforts are continually made to ensure FINDME is part of the discussion. "When talking about DME, we're talking about FINDME"

Management Summary

FINDME is a nonprofit 501c3 organizations operated through a CEO and overseen by a board of directors. The board is comprised of individuals with an interest in DME. This should include people with disabilities, DME vendors, hospital/health care employees, disability advocates and business professionals.

Management Team

The CEO oversees all eighteen FTE refurbishment staff. All of these sites also rely on volunteers to provide non-skilled cleaning and tracking assistance

Strategy and Implementation Summary

Locations & Facilities

All eighteen FINDME sites minimally consist of one FTE staff, one transport van, and 10,000 square feet in warehouse space. These sites exist in Burlington, Cedar Rapids, Council Bluffs, Davenport, Dubuque, Fort Dodge, Iowa City, Mason City, Ames, Ottumwa, Sioux City, Waterloo and Des Moines. All sites maintain a set series of protocols and equipment to allow for safe, clean and effective refurbishment activities.

Technology

FINDME utilizes a multi-user account controlled web platform. This platform allow interaction with a massive online database of durable medical equipment. While equipment that has been within the program later than 90 is view-able by all special permission is needed to see the entire inventory and manipulate the data within. By setting different control options for users care managers are able to identify appropriate DME and FINDME staff are able to update and enter DME.

Financial Plan

Use of Funds

First year budgeted expenses are solely for the costs of start up and do not include costs associated with actual procurement of refurbishing services in the community in which it is based. These first year startup costs are primarily associated with the rental of warehouse space, purchasing of fleet vehicles, negotiations of ongoing funding and development of formal partnerships. After the initial startup period of one year projections are developed using a minimal staff model and low utilization, After two years of existence it is forecast that FINDME would need to hire more staff and possibly more space to meet demand for refurbishment in the state,

Sources of Funds

Financing of FINDME comes from insurance programs that wish to see the DME purchased for their clients being refurbished for use by other members of that program. These programs primarily include Iowa Medicaid but also the major insurers within the state.

Statements

Projected Profit & Loss

| | FY2017 | FY2018 | FY2019 |
|---------------------------------|--------------------|--------------------|---------------------|
| Revenue | \$5,125,000 | \$5,125,000 | \$12,825,000 |
| Direct Costs | \$1,177,414 | \$1,177,414 | \$1,177,414 |
| Gross Margin | \$3,947,586 | \$3,947,586 | \$11,647,586 |
| Gross Margin % | 77% | 77% | 91% |
| Operating Expenses | | | |
| Salary | | | |
| Employee Related Expenses | | | |
| Total Operating Expenses | | | |
| Operating Income | \$3,947,586 | \$3,947,586 | \$11,647,586 |
| Interest Incurred | | | |
| Depreciation and Amortization | | | |
| Income Taxes | \$0 | \$0 | \$0 |
| Total Expenses | \$1,177,414 | \$1,177,414 | \$1,177,414 |
| Net Profit | \$3,947,586 | \$3,947,586 | \$11,647,586 |
| Net Profit / Sales | 77% | 77% | 91% |

Projected Balance Sheet

| | FY2017 | FY2018 | FY2019 |
|---------------------------------------|--------------------|--------------------|---------------------|
| Cash | \$3,947,586 | \$7,895,172 | \$19,542,758 |
| Accounts Receivable | \$0 | \$0 | \$0 |
| Inventory | | | |
| Other Current Assets | | | |
| Total Current Assets | \$3,947,586 | \$7,895,172 | \$19,542,758 |
| Long-Term Assets | | | |
| Accumulated Depreciation | | | |
| Total Long-Term Assets | | | |
| Total Assets | \$3,947,586 | \$7,895,172 | \$19,542,758 |
| Accounts Payable | \$0 | \$0 | \$0 |
| Income Taxes Payable | \$0 | \$0 | \$0 |
| Sales Taxes Payable | \$0 | \$0 | \$0 |
| Short-Term Debt | | | |
| Prepaid Revenue | | | |
| Total Current Liabilities | \$0 | \$0 | \$0 |
| Long-Term Debt | | | |
| Total Liabilities | \$0 | \$0 | \$0 |
| Paid-in Capital | | | |
| Retained Earnings | | \$3,947,586 | \$7,895,172 |
| Earnings | \$3,947,586 | \$3,947,586 | \$11,647,586 |
| Total Owner's Equity | \$3,947,586 | \$7,895,172 | \$19,542,758 |
| Total Liabilities & Equity | \$3,947,586 | \$7,895,172 | \$19,542,758 |

Appendix IV: RFP Proposal

PROPOSAL FORMAT AND ORGANIZATION

Chapter 1 – Bidder’s Summary

The Iowa Program for Assistive Technology or IPAT is a federally funded project under the Assistive Technology Act of 1998, as amended in 2004, PL 108-364, through the U.S. Department of Health and Human Services Administration on Community Living (ACL). IPAT began operation in 1989 with funding from the Technology-Related Assistance for Individuals with Disabilities Act of 1988. This legislation, known as the Tech Act, intended that all states and territories would have programs to increase citizens' awareness of and access to AT. In 1994, Congress reauthorized the Act and emphasized that programs should work toward eliminating barriers to AT access for their constituents. The Assistive Technology Act of 1998 continued support for state AT programs, but reduced the amount of funding available after the program's eighth year of operation. IPAT is now funded through the U.S. Department of Health and Human Services Administration on Community Living (ACL), which is made possible through the Assistive Technology Act of 1998 as amended in 2004 (ATA 2004). IPAT currently administers five core areas to meet the assistive technology needs of Iowans with disabilities.

State Financing Activities

IPAT contracts with the Iowa Abilities Fund to manage Iowa’s alternative financing program (AFP), the Iowa Able Foundation. It provides loans to people with disabilities and their families for the purchase of AT devices and services. In addition to the guarantee, the Iowa Able Foundation offers other flexible options, such as a reduced interest rate and longer loan terms with smaller payments. Abilities Fund also operates the telework grant, which issues loans to persons with disabilities to purchase computers and other equipment needed to work from home.

Device Reutilization

IPAT contracts with Iowa COMPASS, Iowa's disability information and referral service, to manage the Used Equipment Referral Service (UERS), a free service that operates like a newspaper want ad and lists used devices for sale by consumers and AT vendors. IPAT is also the primary financial supporter for Easter Seals Iowa equipment service, a device recycling program that accepts donated used devices from across the state, cleans and refurbishes the AT, and provides the devices to individuals who would not otherwise be able to acquire them. In addition, IPAT continues to maintain a comprehensive listing of all the device reutilization and recycling programs in Iowa and neighboring states, and make this information available through Iowa COMPASS.

Device Loan

IPAT supports the Disability Resource Library (DRL) at the Center for Disabilities and Development to administer a short-term device loan program to allow consumers to try devices or software before purchasing them. This is a limited program primarily for augmentative communication devices and educational software.

Device Demonstration

IPAT contracts with Easter Seals Iowa to operate a statewide device demonstration center located in Des Moines. The center focuses on devices for community living and activities of daily living.

State Leadership Activities

IPAT engages in a number of activities to improve access to AT devices and services. Technical assistance and training are provided to agencies and organizations relating to education, employment, community living and emergency preparedness.

Furthermore, as one of 56 networked assistive technology programs across the nation, ABLE Tech is uniquely positioned, benefits from, and has access to national resources and materials specific to DME reutilization, including the National Technical Assistance Project, Pass It On Center. ABLE Tech will establish protocols utilizing the Indicators of Quality for AT Reuse to ensure quality services to consumers throughout the entire process.

IPAT would propose the following for the Iowa Medicaid DME Recycle Program (IMDRP) for Iowa Medicaid Health Link Members to be conducted:

- Establish an office and warehouse as well as hire staff for a centrally located office,
- Organize a system of drop off points for unused DME,
- Tag and organize retrieval of core listed DME (attachment B) purchased by Iowa Medicaid (DHS),
- Arrange for Health Link Approved DME vendors that can refurbish, sanitize and redistribute equipment that has been retrieved,
- Dispose of any equipment that is not reusable,
- Coordinate with Health Link Care Coordinators on the redistribution of appropriate equipment to Health Link members within 60 days of retrieval
- Coordinate with community based programs to redistribute appropriate equipment to non-Health Link members after 60 days of retrieval,
- Maintain a toll free number and a secured, fully accessible website that will provide information to DHS staff, contracted vendors, and the general public,

- Develop and manage a secured web-based data system for tracking all components of the IMDRP according to HIPPA as well as DHS policies and procedures,
- Outreach to agencies and organizations that serve individuals with disabilities, aging population, and other stakeholders
- IPAT will establish refurbishment policies and procedures utilizing the Quality Indicators created by the national Pass-It-On Center, and
- Provide monthly reporting to DHS as outlined in the RFP.

Chapter 2 – Technical Response

A. DME Tagging and Removal

- I. DHS will provide the Iowa Medicaid DME Recycle Program (IMDRP) with information on DME that has been authorized for purchase for a Health Link member by a contracted DME vendor. IMDRP will maintain appropriate methods of inventory tracking as these are essential for capturing program information, keeping accurate financial records, determining the availability of specific types of devices with ease and ensuring the safety of customers. For the purpose of creating a barcode and information record for each device IMDRP will include at a minimum the following:
 - unique identification of every retrieved device utilizing a barcode system,
 - ability to determine the availability of devices by type,
 - assignment of an inventory valuation to each device,
 - a methodology for assigning value to specific devices by type/model/age, etc.,
 - an equipment “value list” based on this methodology for use by staff performing inventory entry, and
 - training for staff who enter items into inventory in the use of the method and the list.

The industrial barcode label can be created by the contracted DME vendors through the IMDERP tracking website using equipment the vendor already has. These labels are designed to resist daily repeated use, tampering or accidental removal. This barcode label will also include authentication of DHS ownership and a toll free number to call for retrieval. The core DME list of items that will have this sticker will include:

1. Augmentative Communication Devices
2. Bath Benches
3. C-PAP's

4. Commodes
5. Gait Trainers
6. Hospital Beds (Semi-Electric)
7. Hospital Beds (Electric)
8. Patient Lifts
9. Quad Canes
10. Scooters (Power Operated Vehicles)
11. Shower Chairs
12. Stenders
13. Walkers
14. Wheelchairs Power
15. Wheelchairs Manual

Along with barcoding/tagging of new DME for Medicaid members the IMDRP will institute a follow-up program to ensure that the device is being utilized as intended. IMDRP staff will contact Health Link members that have received DME within 7 business days of delivery by the vendor. IMDRP will specifically inquire on usage and any further needed training or supports to ensure usage. This same contact will be made within the first six months of acceptance of DME and then annually thereafter. This mechanism would be instituted to ensure that DME was not being resold or put in storage without utilization.

When a Health Link member, family or providers no longer needs the equipment, either through the follow-up system or by direct contact with IMDRP arrangements are made to reacquire that equipment. During that contact the Health Link member has the option to deliver the equipment to one of several drop off locations throughout the state or wait (up to 14 business days) for pick-up through the IMDRP DME transportation service. IMDRP will implement a transportation system that will pick up or drop off equipment when a vendor or member cannot do so otherwise.

If the DME has been purchased by DHS prior to the tagging system but within the last 5 years, IMDRP will barcode all retrieved equipment that is deemed reusable and track the redistribution of that equipment utilizing the new barcode number. IMDRP will monthly report this equipment to the DHS staff in order for a possible match with a Health Link member to reuse the appropriate equipment.

For items that need repair, when necessary, IMDRP will pay a contracted vendor to make repairs that will meet manufacturer's specifications. Repairs that cost more than 60% of the replacement value of the DME will not be pursued. IMDRP will properly dispose of any equipment that is not deemed reusable through the Iowa Surplus Property Program. Additionally, the IMDRP will not accept any DHS equipment that is more than 5 years old.

IMDRP will rent a facility that is located in a place that:

- is physically accessible and safe for employees, contractors, volunteers and customers,
- complies with building codes and other applicable ordinances,
- holds required drills for fire, weather and evacuation,
- has implemented policies and procedures that prevent customers from entering work and storage areas,
- uses secure storage for chemicals and tools,
- has a separate area for administration and program records,
- has a private area for customer intake,
- has a separate area for device matching,
- has a separate area for device refurbishing and sanitizing, and
- has appropriate areas for unloading and loading equipment.

The IMDRP will utilize a leased vehicle with proper loading features and/or accessorizes (lifts, dollies, lift-truck as needed.) Drivers will have current licenses and safe driving records and will be trained in safe lifting and handling techniques.

- II. A comprehensive secured fully accessible data system will be developed that would include, but not be limited to, systems utilized to track and identify inventory, track utilization, and maintain confidential client files and will ensure confidential, timely sharing of available equipment. Assistive Technology for Kansans (currently contracts with the Kansas Medicaid agency for DME reuse) has agreed to provide technical support during the software development phase. The program will initially only retrieve items specified within the RFP in Attachment B.

B. Refurbishment

- I. The program will develop written, device-specific procedures that are applied consistently for evaluating equipment for repair or refurbishment. The sanitization and refurbishment will be completed by a trained professional that will use appropriate tools chemicals and processes that are consistent with the manufacturer's instructions. Additionally, the work area will be climate controlled with adequate plumbing and air handling facilities. Equipment will be stored in separate areas for newly-retrieved equipment from equipment that has been refurbished and sanitized to avoid cross contamination and to identify devices ready for reuse. For items that need repair, IMDRP will pay a DHS approved contracted vendor to make repairs that do not cost more than 60% of the replacement value. All DME will be stored in the leased facility in centrally located area within the state.
- II. IMDRP will properly dispose of any equipment that is not deemed reusable by the Iowa Surplus Property Program. The program will develop policies and procedures based on sound medical or scientific practice and that are consistent with the manufactures recommendations for the sanitization and the refurbishment of equipment.
- III. The IMDRP will maintain an inventory of retrieved items as long as reuse is viable. All items that have been in the reuse inventory for a 12 month period will be reassessed for continuing in the reuse inventory. If the assessment, as established by policies and procedures, determines the item should no longer remain in inventory it will be disposed through the Iowa Surplus Property Program.

c) DME Redistribution

- I. A comprehensive secured fully accessible web data system will be developed and maintained that will be available to DHS staff, all community based programs and the general public. The web data system will only identify items which Health Link members can access for the first 60 days with the assistance of the Health Link Care Managers. A database of available items for the general public will be made available after the initial 60 day retrieval date. The program will initially only retrieve items from the core DME list outlined.
- II. Health Link Care Managers will determine Health Link members needs and appropriateness of reused equipment based on their authorization system. The IMDRP will put in additional steps for a non-Health Link members to access retrieval items through the requirement of an application process. The application will seek additional information pertaining to insurance, health, financial status, residential setting, and DME needed to assist with appropriate determination of match and assignment. Other factors include:
 - Require the person to have a medical prescription on certain devices,
 - Ensure the device is consistent with the recommendation of the prescribing professional, and
 - Coordinate with community based providers to assist individuals through the application process.
- III. The IMDRP will respond to requests for DME within three business days. Every effort will be made to set an appointment at the time of the request. If an appointment time can't be established within 24 hours, policy will establish an estimated time for follow-up with the individual making the request. Delivery of equipment for both Health Link and non-Health Link members will be provided at no cost.
- IV. IMDRP will provide skilled instruction at no cost to the individual receiving the redistributed equipment on the proper use, design, and capabilities of the DME according to Center for Medicare and Medicaid Services (CMS) and manufacturer guidelines; and obtain and retain an acknowledgement of such training from the individual or the individual's authorized representative. Additionally training will include the following features:
 - be accessible to the customer,
 - include the direct support provider(s) or family member as appropriate,
 - explain the features and safe operation of the device,
 - explain basic maintenance procedures for the device,
 - explain troubleshooting and support techniques, and
 - obtain a liability release from the non-Health Link member.

- V. IMDRP will implement an IVR (Interactive Voice Response) system to gather customer service satisfaction in addition to the follow-up system previously described. This IVR system utilizes automated phone system where recipients can respond either through the buttons on their phone or by voice to a series of customer service questions. This call will be made two (2) weeks after receiving equipment from the IMDRP for both Health Link and non-Health Link members. Implementing an IVR will allow for both anonymity in responses as well as ease of use as compared to traditional mail-based surveys.

d) Outreach

- I. IMDRP will establish a toll free line for easy telephone access. Users that wish to communicate through alternative systems will be urged to utilize relay services through 711 Iowa Relay. The phone line will have a voice mail function that will allow anyone to leave a message at any hour convenient for them. In addition, IMDRP will maintain a published email account along with a public website for anytime contact information. Public hours of operation will be 9:00 a.m. to 4:00 p.m. Monday through Friday except legal holidays. If demand warrants, one Saturday a month additional hours may be introduced. Office hours will be maintained 8:00 a.m. to 5:00 p.m. Monday through Friday.
- II. IMDRP will educate Health Link-contracted DME providers in on the value of the program, this will be accomplished via mail, web, meetings, and disability related conferences, etc. IMDRP will develop and implement an outreach campaign targeting programs and agencies. All elements of the outreach campaign shall be subject to the approval of IPAT. IMDRP will optimize the use of its marketing resources:
- by identifying target audiences such as the elderly and individuals with disabilities,
 - by using the most cost-effective means of reaching that audience,
 - by utilizing People First Language in program publications, and in all other facets of the program,
 - by collaborating with organizations that focus on specific disabilities (e.g., United Cerebral Palsy),
 - by collaborating with community institutions that reach specific age groups (e.g., schools and Senior Citizens centers),
 - by collaborating with governmental agencies or community organizations whose clients may be uninsured or unable to afford DME,
 - by collaborating with as many organizations as possible to identify potential users and to reclaim AT for reuse, and

- any marketing materials will be made available, upon request, in alternative formats.
- III. In the initial phase of operation IMDRP does not plan to subcontract with DME contracted vendors with the exception of complex repairs. Repairs will be paid on a fee for service basis. However, as the program's demand and volume increase, subcontracts may be established with contracted DME vendors. IMDRP will coordinate subcontracts with DHS and gain full approval prior to any subcontract being established.
 - IV. IMDRP will develop and implement one or more methods to inform Health Link members that DME belongs to DHS and must be returned at the end of use. The DME contracted vendor will place a sticker on each item of the core DME list prior to delivery. The sticker will state that the equipment is the property of the State of Iowa, and to contact IMDRP if the item is no longer needed by the Health Link member.
 - V. The mission of the Iowa Program for Assistive Technology is to get assistive technology into the hands of Iowans with disabilities through activities that provide increased access and acquisition. This statewide program for Iowans is a program of Iowa's University Center for Excellence on Disabilities. IPAT is located at the Center for Disabilities and Development at the University of Iowa Children's Hospital in Iowa City, IA. The University of Iowa will be the contracting entity if IPAT is the successful bidder. IPAT maintains an advisory council, the Iowa Council on Assistive Technology. A majority of the members are individuals with disabilities or a family member of a person with a disability to seek advice and support for planning, implementing, and evaluating the activities to be carried out by IPAT to meet its mission.
 - VI. The Center for Disabilities and Development (CDD) has been designated as Iowa's University Center for Excellence on Developmental Disabilities (UCEDD) since 1972. Established by the Iowa Legislature in 1947 as a residential "hospital school," CDD has evolved over the years in response to every major advance in disability policy in the United States. The passage of PL 94-142 in 1975, for example, spurred CDD's transition from being a residential school to serving as Iowa's tertiary level diagnosis and evaluation center supporting Iowa schools and community programs. The Center for Disabilities and Development (CDD) shares the vision of "a life in the community for everyone." The Center for Disabilities and Development is a part of University of Iowa's Hospital and Clinics. We are dedicated to improving the health and full community participation of people with disabilities and advancing the community supports and services on which they rely. CDD partners with Iowans with

disabilities, their family members, providers, state and local agencies, and many other stakeholders to achieve our mission and vision.

- VII. IPAT has over 17 years of experience as the Assistive Technology Act Program for the State of Iowa. IPAT has a well-established history of building relationships and collaborating with both public and private entities for the provision of assistive technology for all Iowa with disabilities. Furthermore, as one of 56 networked assistive technology programs across the nation, IPAT is uniquely positioned, benefits from, and has access to national resources and materials specific to DME reutilization, including the National Technical Assistance Project, Pass It On Center. IPAT will establish protocols utilizing the Indicators of Quality for AT Reuse to ensure quality services to consumers throughout the entire process.

Currently, IPAT barcodes and tracks over 4,141 pieces of assistive technology placed through Easter Seals of Iowa across the state for the purpose of a short term lending program. IPAT will need to develop a specialized, secured web-based computer program that will be shared by the IMDRP, IPAT and stakeholders to ensure confidential, timely sharing of available equipment. Assistive Technology for Kansans (currently contracts with the Kansas Medicaid agency for DME reuse) has agreed to provide technical support during the software development phase.

IPAT an entity of the University of Iowa, provides a well-established and experienced collection of personnel and procedures for contract management functions. The project director has successfully managed federally and state funded projects and managed an annual budget of nearly \$3,000,000 in FY 2015. All administrative and management activities are carried out under the dual requirements of the university and the state and therefore are assured to be completed in a systematic and responsible fashion.

This overall administrative, management, and facilitation system is well-staffed and well-equipped to provide optimal support functions for this project including, budget monitoring services, communication systems, personnel management in accordance with affirmative action guidelines, and the required reporting functions.

Chapter 3 – Staffing and Reporting Requirements

- a) IPAT will subcontract the responsibilities of the IMDRP.
- b) IMDRP will track each request, retrieval, and redistribution by person and item. This will create a database with a wealth of information that ultimately will be available in various data set requests. This will enable IPAT and IMDRP to analyze various trends, dates between requests, retrieval and reuse, by value, type of category, and net savings. Client files containing personal and programmatic information such as, name, address, Medicaid number, along with data maintained on non-Health Link members to include, health status, insurance, financial status, residential setting, prescribing professional and liability release will be maintained. All client files will include record of training on redistributed DME. All client files will be maintained under HIPPA standards.

Below are example reports that include the monthly inventory report along with data that will be aggregated based on individual client and inventory data.

Report for the Month of _____

| Devices Requested | # by HealthLink Member | Average # of Days Waiting for Item | # by HealthLink Member | Average # of Days Waiting for Item |
|--|------------------------|------------------------------------|------------------------|------------------------------------|
| 1. Augmentative Communication Devices | | | | |
| 2. Bath Benches | | | | |
| 3. C-PAP's | | | | |
| 4. Commodes | | | | |
| 5. Gait Trainers | | | | |
| 6. Hospital Beds (Semi-Electric) | | | | |
| 7. Hospital Beds (Electric) | | | | |
| 8. Patient Lifts | | | | |
| 9. Quad Canes | | | | |
| 10. Scooters (Power Operated Vehicles) | | | | |
| 11. Shower Chairs | | | | |
| 12. Standers | | | | |
| 13. Walkers | | | | |
| 14. Wheelchairs Power | | | | |

Chapter 4 Bidder's Past Performance and References

- a) successful contracts (not included)
- b) letters of reference (not included)
- c) IMDRP will contract with an organization to build a fully accessible secured website that will maintain all client and inventory records. The website will have different levels of administrative rights that will allow the IMDRP, DHS and community based providers along with the general public to have access to needed information. The subcontracting entity will be chosen based on ability to ensure the website meets the Section 508 Standards for Electronic and Information Technology, proven past performance, and cost. Additionally, IMDRP will subcontract with contracted DME vendors to complete complex repairs that will not exceed 60% of the value of the piece of equipment.
- d) IPAT has not had any contract action taken against it on any contract in the past 5 years.

ATTACHMENT A - MANDATORY REQUIREMENTS

| | |
|----------------------------|--|
| Tax Identification Number: | |
|----------------------------|--|

| Board of Regents for the State of Iowa | | |
|---|--------------------------|--|
| http://www.regents.iowa.gov/BoardMembers/boardmembers.html | | |
| Board Member Name | Board Member Title | Board Member Contact Information |
| Bruce Rastetter | President | (515) 854-9844 E-mail: regentbr@iastate.edu |
| Katie Mulholland | President Pro Tem | (319) 533-5491 E-mail: regentkm@iastate.edu |
| Mary Andringa | | (641) 621-7705 E-mail: regentma@iastate.edu |
| Sherry Bates | | (712) 652-3832 E-mail: regentsb@iastate.edu |
| Patricia Cownie | | E-mail: regentpc@iastate.edu |
| Milt Dakovich | | (319) 232-6537 E-mail: regentmd@iastate.edu |

| | | |
|-------------------|--|--|
| Rachael Johnson | | (319) 273-6376 E-mail: regentri@iastate.edu |
| Larry McKibben | | (641) 752-6908 E-mail: regentlm@iastate.edu |
| Dr. Subhash Sahai | | (515) 832-6123 E-mail: regentss@iastate.edu |

| Business Name | Business Address | Business City |
|---------------------------------------|-------------------|---------------|
| Iowa Program for Assistive Technology | 100 Hawkins Drive | Iowa City |
| | | |

| Business County | Business Zip |
|-----------------|--------------|
| Johnson County | 52242 |

| | |
|----------------------------------|--|
| Date Organization Formed: | |
|----------------------------------|--|

ATTACHMENT B - CORE DME LIST

| |
|--|
| 1. Augmentative Communication Devices |
| 2. Bath Benches |
| 3. C-PAP's |
| 4. Commodes |
| 5. Gait Trainers |
| 6. Hospital Beds (Semi-Electric) |
| 7. Hospital Beds (Electric) |
| 8. Patient Lifts |
| 9. Quad Canes |
| 10. Scooters (Power Operated Vehicles) |
| 11. Shower Chairs |
| 12. Standers |
| 13. Walkers |
| 14. Wheelchairs Power |

ATTACHMENT C -COST PROPOSAL - DME RECYCLE PROGRAM


PROPOSED PRICE BY STATE FISCAL YEAR (SFY): JULY 1ST THROUGH JUNE 30TH

| | SFY2016 | SFY2017 | SFY2018 | SFY2019 |
|--|---------|---------|---------|---------|
| Pick up Medical Equipment from Health Link Members' homes | 45,388 | 45,388 | 154,226 | 154,226 |
| Sanitizing equipment | 45,388 | 45,388 | 154,226 | 154,226 |
| Refurbishing equipment | 45,388 | 45,388 | 154,226 | 154,226 |
| Storing equipment per month (including any administration of handling & inventory charges) | 45,388 | 45,388 | 154,226 | 154,226 |
| DME Redistribution | 45,388 | 45,388 | 154,226 | 154,226 |
| Customer Satisfaction Survey | 2,670 | 2,670 | 9,071 | 9,071 |
| Marketing Campaign | 37,378 | 37,378 | 127,008 | 127,008 |
| Total Annual Price | 266,988 | 266,988 | 907,209 | 907,209 |

Appendix V: Tracking and Retrieval Database (screenshots)

| Primary Contact | Secondary Contact |
|-------------------|----------------------|
| First Name | Billbo |
| Last Name | Baggins |
| Address | 400 W. Fourth Street |
| Apt/Ste/Lot : | |
| State | IA |
| Primary_City | Waterloo |
| Zip | 50703-8973 |
| Primary Phone | (319) 765-8439 |
| Secondary Address | 543 Newell St |
| SecondaryPhon | |
| Apt/Ste/Lot # | |
| City | Waterloo |
| State | IA |
| Zip | |

FIGURE 1 - MEDICAID MEMBER TRACKING SCREEN

 **Equipmen**

| | |
|-----------------|--------------|
| Manufacturer | Infinitec |
| Model | Rodeo |
| Vendor Originat | Hammer |
| S/N | #Name? |
| SKU | usdf-823479j |
| RSA_Type | Mobility |
| RSA_subcat | Power Chair |
| Condition | Excellent |
| MSRP\$ | \$17,000.00 |
| Condition_ID_C | 4 |

Patient_Equipment subform 1

FIGURE 2 - DEVICE INFORMATION SCREEN

 Vendor

Company_Name:

DBA_Name:

Address_1:

Address_2:

State:

City:

Zip:

Phone:

Fax:

Email:

| Equipment | S/N | SKU | Manufactu | Model | RSA_Type | RSA_subcat | Conditic | MSRP\$ |
|-----------|--------|---------------|-----------|--------|----------|-------------|----------|-------------|
| 3 | #Name? | usdf-823479j | Infinitec | Rodeo | Mobility | Power Chair | | \$17,000.00 |
| 4 | #Name? | fsdg-435329g | DARPA | Xavier | Mobility | Power Chair | | \$43,000.00 |
| 5 | #Name? | asdf0-4487456 | Invacare | R7 | Mobility | Power Chair | | \$4,500.00 |
| * | (New) | | | | | | | |

FIGURE 3 - VENDOR INFO SCREEN