

Wheelchair Repair Task Force Final Report and Recommendations - February 1, 2024

I want to thank Human Services Committee Chairs Senator Matt Lesser and Representative Jillian Gilchrest for appointing me Chair of the Wheelchair Repair Task Force. It has been an honor. I also want to thank Human Services Committee Ranking Members Senator Lisa Seminara and Representative Jay Case for their active participation and extra time spent with me. Additionally, I want to thank Task Force participants Representative Frank Smith, Complex Rehabilitative Technology* (CRT)/wheelchair consumers, advocates, disability rights experts, technicians, CRT industry representatives, insurance industry representatives, and State Agency appointees for their commitment, energy, expertise and time. And lastly, I want to extend a special thank you to the Human Services Committee Clerk, Chandra Persaud, for sharing her expertise, knowledge and support of our Task Force and its members.

The Wheelchair Repair Taskforce (Taskforce) was established under [Special Act No. 23-22 AN ACT ESTABLISHING A TASK FORCE TO STUDY MINIMUM STANDARDS FOR TIMELY REPAIR OF COMPLEX REHABILITATION TECHNOLOGY.](#)

Despite lots of new information, data and research, high emotions, complex multi-faceted problems, challenging dialogue, and substantive disagreement, all Taskforce members respectfully and honestly engaged, remained committed to our process, and never gave up.

As the Chair of this Task Force, I understand legislators will weigh many different variables in terms of what can be passed that is substantive and real for wheelchair users. While I personally favor some kind of regulation(s) as the surest way to ensure consumers a reliable repair and service timeline, I understand this is a complex and challenging task in which legislators will need to deliberate, and I want to acknowledge the CRT industry for their continued involvement - prior to the official Taskforce statute was passed - and focus on improving these timelines.

For context, there are over five million wheelchair users in the United States. The number of users in CT is difficult to ascertain however DSS reports that the wheelchair user population on Medicaid is about 4800 individuals, or 0.44% of Connecticut's Medicaid population overall. According to data from National Seating and Mobility (NSM) and NuMotion they provide services for about 6500 wheelchair/CRT users - not broken down by payer status.

By way of background and to establish a framework for our readers to best understand the importance of establishing substantive policies for timely repair and service of wheelchairs, that honor the experiences of wheelchair users, I invite readers to read this comprehensive 2023 report [Wheelchair Provision Guidelines](#) authored by the World Health Organization, The International Society of Wheelchair Professionals, and International Society for Prosthetics and Orthotics**.

From the Report's Forward:

“Wheelchairs provide mobility, postural support and freedom to those who cannot walk or have difficulty walking, enabling them to move around, participate in everyday activities and live life on their own terms. As one of the most commonly used assistive products, wheelchairs are a vital asset, enabling access to places and activities that would otherwise be inaccessible.

For children, wheelchairs provide a sense of freedom, independence, and inclusion necessary for their physical, emotional and social development. For older people, who make up a growing group of users, wheelchairs can enable continued participation in everyday activities, maintaining an active lifestyle, and living with dignity.”

Four Guiding Principles that underpin Report findings and recommendations:

1. An appropriate wheelchair is a human right.
2. Wheelchair provision services and systems should place people at the center.
3. Wheelchair provisions should be an integral component of universal health coverage.
4. Access to appropriate wheelchairs should be equitable.

It is my hope that this report accurately reflects the serious, inclusive and transparent approach I, along with all Taskforce members, took to address the problems experienced by wheelchair users when their equipment is in disrepair.

And to all who take the time to read and act upon this report which has truly been a labor of love, respect and solidarity - thank you.

Sincerely,

Beverley Brakeman

Beverley Brakeman, Chair

* Throughout this report you will see the terms complex rehabilitation technology (CRT) and wheelchair used somewhat interchangeably. For purposes of this report, CRT largely refers to customized wheelchairs (both manual and electric), as that was our specific purview. However, the statutory definition of CRT is broader and reads as follows: “Complex rehabilitation technology” means products classified as durable medical equipment within the Medicare program as of January 1, 2013, that are individually configured and medically necessary for individuals to meet their specific and unique medical, physical and functional needs and capacities for basic and instrumental activities of daily living. Complex rehabilitation technology includes, but is not limited to, (A) complex rehabilitation manual and power wheelchairs and accessories, (B) adaptive seating and positioning items and accessories, and (C) other specialized equipment and accessories, such as standing frames and gait trainers.

**It should be noted that this report is not focused exclusively on repair and service, but rather on the over-arching importance that well-fitted, regularly maintained, and rapidly repaired wheelchairs play in the lives of those who use them.

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Wheelchair Repair Task Force Membership

Chair

Beverley Brakeman Appointed by Senator Lesser as designee

Members

Sen. Lisa Seminara Senate Human Services Committee Ranking Member
Rep. Jay Case House Human Services Committee Ranking Member
Rep. Frank Smith Appointed by Representative Gilchrest as designee
David Morgana Appointed by Speaker Ritter
Jonathan Sigworth Appointed by Speaker Ritter
Rick Famiglietti Appointed by Senator Looney
Michelle Duprey Appointed by Senator Looney
Joseph Shortt Appointed by Representative Rojas
Seth Johnson Appointed by Representative Rojas
Melissa Marshall Appointed by Senator Duff
Sheldon Toubman Appointed by Senator Duff
Wayne Grau Appointed by Representative Candelora
Diane Racicot Appointed by Representative Candelora
John Lee Goetz Appointed by Senator Kelly
Gary Gilberti Appointed by Senator Kelly
Susan Halpin Appointed by Senator Lesser
Darrell Ruopp Appointed by Representative Gilchrest
Jon Slifka Appointed by Commissioner Porter as designee
Shirley Skyers-Thomas Appointed by Commissioner Cafferelli as designee
Ginny Mahoney Appointed by Commissioner Barton Reeves as designee
Barbara Cass Appointed by Commissioner Juthani as designee
Jim Carson Appointed by Commissioner Mais as designee

Taskforce Meetings and Presentations

August 31st	<i>Introductions and Committee Goals</i> Minutes Committee Timeline Presentation
September 20th	<i>Industry Response to Consumer Priorities Discussion</i> Minutes
October 4th	<i>Insurance Industry, DOI and DSS Presentations on Payer Status</i> Minutes DSS Presentation - CRT Prior Authorization and Medicaid (Addendum A)
October 18th	<i>State Agency Presentations</i> Minutes DSS Presentation on CRT Data (Addendum A) Office of State Comptroller (Addendum B)
November 2nd	<i>CRT Industry Presentation</i> Minutes Industry Presentation on State of the Industry (Addendum C)
November 9th	<i>Consumer Advocate Presentation on CRT and Priorities</i> Minutes Consumer Advocate Presentation (Addendum D)
November 16th	<i>Industry Response To Consumer Priorities</i> Minutes Industry Response Document (Addendum E)
November 30th	<i>Discussion of Survey Results</i> Minutes
December 7th	<i>Continued Discussion Policy Priorities</i> Minutes
December 14th	<i>Chair Outlines Steps for Completion of Report</i> Minutes
January 18th	<i>Review of Draft Final Report</i> Minutes
January 25th	<i>Continuation of Discussion on Final Report</i> Minutes
January 31st	<i>Vote on Final Report</i>

Task Force Findings

The Task Force focused on gathering information and collecting data in four specific areas:

- Consumers' and Advocates' Experiences
- State of the CRT Industry
- CRT Payers - Medicaid, State Comptroller, and Fully Insured Market

Key Findings as Reported by Consumer Advocates

1. Stories from wheelchair users having experienced delays in wheelchair repair and service were heard by the Task Force. The complaints involved long wait periods, lost parts, transportation issues and more.
2. Consumer advocates conducted informal community-based surveys (surveys were not reviewed by Task Force as a whole) of wheelchair users during the time the Taskforce met and found the following:
 - a. Of 73 consumers responding to a consumer survey, 56 waited for repairs 1 month to more than 6 months.
 - b. In another informal survey of 16 respondents, 76% heard from the repair company within 3 days, 24% more than 4 days, 13% waited up to an entire month 31% had their repair evaluated within 3 days, 69% waited from 1 week to more than 1 month.
3. Consumers reported hearing from their community that some CRT users felt compelled by CRT providers to come to repair shops, which is a burden for many if not most consumers.

Key Findings as Reported by CRT Industry Representatives

Key steps in the Repair Process include:

- a. Customer Intake - type of equipment, problem, insurance;
 - b. First the service provider will assess whether the issue is still covered under the manufacturer's warranty to determine how to approach the repair. If not covered under warranty, the service provider will notify the customer that it is a non-warranty repair and continue with the consumer's insurance provider;
 - c. Insurance Verification - what is covered, Rx needs, PA requirements;
 - d. Repair Assessment Appointment - Can be done remotely, provider location, or in-home. The industry indicates 90% of assessments currently take place in the home which limits repair tech capacity by about 50%;
 - e. Assessment of Loaner Equipment Needs - Loaner equipment is generally not customized;
 - f. Repair technician conducts the necessary repair in shop or in home with the majority happening in home which industry contends is a key factor in increasing wait periods. Suppliers can do on average 4.5 in-home repairs per day vs. 7.5 average repairs in shop
 - g. Repair technician completes and service provider submits documentation to insurance provider;
 - h. Follow up repairs are completed and provider engages with insurance to receive authorization of payment.
2. There are currently 2 primary service providers in CT - NuMotion and National Seating and Mobility. The following can be found in this report and is summarized below:
 - a. Each company currently has 14 repair technicians;

- b. NuMotion has 47% of the CT Market and NSM 45% based on revenue. There are two other small service providers licensed to do repairs in CT - Home Health Pavilion and Agawam - that have about 8% of the market;
 - c. Both companies are headquartered in Nashville TN. NuMotion has been in business 40 years and has offices in Rocky Hill, CT and NSM has been in business 30 years and has offices in Newington and Niantic, CT;
 - d. Both companies sell, service and repair manual, power and ancillary equipment:
 - i. NSM - 34% Manual, 60% Power, 6% Ancillary
 - ii. NuMotion - 33% Manual, 27% Power, 40% Ancillary
 - e. Breakdown of payer status by company is as follows:
 - i. NSM - 56% private/commercial, 20% Medicare, 23% Medicaid, 1% Other
 - ii. NuMotion - 25% Private, 38% Medicare, 37% Medicaid
 - f. Both companies sell new equipment and conduct repairs. The breakdown is as follows:
 - i. NSM - 47% repairs vs. new
 - ii. NuMotion - 58% repairs vs. new
 - g. Repair time varies based on a number of factors including in-home vs. in-shop repairs, whether remote assessment can be done, parts supply and ordering, insurance Rx and PA requirements, transportation needs of consumers, and more. See Industry Report for more details.
 - h. Company data indicates that the time the need for an assessment is identified to the time it is conducted in the post-covid era averages 2-4 days for remote or in-shop and 24-27 days for in-home. The time from when parts are received to installation in a post covid era averages 2-4 days for in-shop and 25-27 days for in-home.
 - i. Prior Authorization under medicaid is required for anything over \$1000. No PA is required under Medicare and private insurance varies but does delay the process anywhere between 1 and 14 business days, with a pre/post-COVID average of 8 days.
 - j. Biggest challenges to timely repair for the industry include:
 - i. Backlog due to Covid (NuMotion has 740 outstanding service orders for 622 customers and NSM has 687 for 445 customers as of November 2023)
 - ii. Payer prior authorization and other requirements
 - iii. Hiring and training of competent staff
 - iv. Supply Chain following Covid.
 - v. No reimbursement for repair travel and assessment
3. Industry investments that are being made or have been made this year to improve repair time:
- a. Accept calls after hours that will be triaged and distributed to the supplier in the morning to identify priority repair calls;
 - b. Conduct remote evaluations within 4 business days or sooner depending on consumer's availability;
 - c. Hire 3 additional technicians for each company and 1 additional customer service positions in total to expedite consumer calls;
 - d. Cross-train individuals in technical positions.
 - e. Inventory Software systems to identify parts in different locations for quicker availability and ship times.
 - f. Expansion of Inventory of common parts that are warehoused in our CT. locations.
 - g. Outsourcing basic repairs to an outside service provider to free up company service technicians.

- h. Suppliers will be repositioning additional service technicians from outside Connecticut to reduce the repair backlog.

Key findings as Reported by DSS on the Medicaid population using CRT:

1. The percent of Medicaid members using CRT is 0.44% or 4,850 members;
2. Of these the majority live at home, in urban areas particularly Hartford and New Haven, and 90% are adults;
3. By far the majority of Medicaid claims are for repairs, of which prior authorizations are required for repairs over \$1000 and about 11.8% of repairs required a PA in 2022;
4. Prescriptions for all repairs are required every two years;
5. Medicaid costs for repairs was \$2.3MM versus \$10MM for new CRT purchases in 2022.

Key findings as reported by the Insurance Industry indicate that Connecticut's regulatory authority only extends to the fully insured market - which only reflects approximately 13% of Connecticut's total population - and/or 25% of commercial insureds. The majority of Connecticut's employers are self-insured which is not regulated by the state but rather by ERISA and as such is not something the CT General Assembly can legislate. Private commercial plans differ based on what is negotiated between employers and insurance companies and insurers and providers so no data was available. Non-regulated ERISA plans sometimes follow the state insurance mandates applicable to fully-insured plans even though this is not required.

Introduction to Task Force Recommendations

All members of the Taskforce agree that the waiting period for repairs and service of wheelchairs must be reduced in order to improve the lives, mobility, independence, and safety of Connecticut's wheelchair users. The overarching goal of the Taskforce is to make recommendations designed to reduce this wait period. The following recommendations are born out of intensive and meaningful dialogue, debate and respectful disagreement.

To that end, it must be noted that none of the following recommendations were met with consensus of the entire Taskforce. In particular, there was wide disagreement between consumers/advocates and CRT industry representatives regarding Recommendation #1. As such, you will see two discussion points under that Recommendation in addition to substantive responses included in Addenda F and G respectively.

In order to fairly represent our findings and recommendations, each stakeholder group was asked to provide responses to the Recommendations. These responses have not been edited or changed in any way by the Taskforce Chair or other members and are included in the Addenda.

It should be noted that State Agency appointees are not in a position to recommend, approve or oppose policy recommendations, but rather to assist Taskforce members in understanding the impact of recommended policy on their agency.

Task Force Recommendations

Recommendation 1:

- CRT equipment must be assessed and then repaired, either in the consumer's home or in a service location of the consumer's choice, within a set period of time that is less than 10 business days after all prior authorizations have been obtained and all parts have been received with exceptions to assessment and repair timeliness requirements in cases where the consumer is not available or cancels.
- This measure must be accountable, enforceable, including penalties for non-compliance with exceptions to assessment and repair timeliness requirements in cases where the consumer is not available or cancels.
- To enforce these timelines, and to address the concerns of some state agencies that they have neither the statutory authority nor the resources or infrastructure to implement and enforce these timelines, we recommend that a state administrative agency, with the pre-existing enforcement infrastructure to carry it out, be statutorily authorized to promulgate and enforce regulations (with penalties) so as to ensure that the timelines are complied with, and that it be provided with the necessary resources to discharge this role.

Consumers and advocates strongly recommend that both in-home and in-shop assessments and repairs be achieved within a period of 4 business days or 6 calendar days. Consumers indicate that having equipment assessed and repaired in their homes on a timeline that mirrors in-shop repair times is extremely important as many consumers cannot travel.

The CRT industry does not support timelines in regulation or statute citing a wide array of often unpredictable and uncontrollable variables impacting timeline for repairs and service. Additionally, the CRT industry will always offer in-home repair, but has indicated it is not feasible to do so in the same timeline as in-shop repairs.

Recommendation #2: Eliminate prior authorization and prescriptions for repairs of CRT.

- Prior authorization for all repair codes should be eliminated.
- The original equipment prescription will be used as authorization for all repairs for up to 5 years.
- Under Medicaid, the requirement for a new prescription for repairs every 2 years should be eliminated.

Under Medicaid, prior authorizations are currently required for repairs over \$1000. Under Medicare, prior authorizations are not required for repairs. In the fully insured private market - which can be regulated by CT statute but excludes self-insured plans - prior authorization for repairs varies widely and has not been compiled.

Recommendation #3: Payers should cover annual preventive maintenance of all CRT.

Currently, wheelchair users must wait until their equipment malfunctions requiring them to seek repairs and endure the often lengthy wait periods. Annual preventive maintenance could serve to prophylactically reduce the need for repairs by helping consumers to maintain well-functioning equipment.

Recommendation #4: Consumers must be offered and provided in-home assessments and repairs within a comparable timeline to that of in-shop repairs.

Consumers have indicated that getting to repair shops can be very challenging. Remote or virtual assessments of equipment is often not possible for some consumers depending upon the level of their condition and mobility. The CRT industry always offers in-home services, but has been clear that this increases the waiting period.

Recommendation #5: Transportation to the CRT location, should a consumer so choose, is a covered benefit and DSS prohibitions on payment for transportation to a wheelchair repair shop should be repealed.

Currently, transportation to a repair location is not covered by any payers, and it is cost-prohibitive for most consumers to pay for this on their own, particularly if they are on Medicaid with its very low income limits and, also for people who are on Medicare. Unfortunately, while DSS has non-emergency medical transportation services available for medical appointments as required by federal law, these services have limited capacity to transport wheelchair users, and transporters may have liability concerns with transporting individual as with broken wheelchairs. In addition DSS does not currently pay for transport to a wheelchair repair shop, and it has regulations prohibiting such payment. These prohibitions should be repealed. If DSS regulations prohibiting such payment are repealed, and NEMT vendors agree to accept the liability for transporting members with broken wheelchairs, this may prove an option for Medicaid enrollees. For individuals on Medicaid, it is not clear that any federal reimbursement will be allowed. As such, the increased cost would need to be state funded.

Recommendation #6: Payers should cover repair technician travel to and from consumer homes for the purpose of providing in-home assessment and repair.

Currently, no payers reimburse for technician travel time, travel costs, and diagnosis time to assess the repair, which causes a hardship for both CRT providers and consumers. Since nearly 85% to 90% of repairs are being performed, and should continue to be performed, in the home, it is essential that the CRT providers be reimbursed for this extra time needed for travel and other out of pocket travel expenses.

Recommendation #7: Annual preventive maintenance of consumer owned back-up equipment should be a covered benefit.

Many consumers have old equipment in the event their current equipment malfunctions. This is a far better option for consumers than having to rely on a loaner chair that will not be customized nor properly fitted leaving consumers at risk of injury or accident. Ideally, customized loaner chairs would be available, but given the diversity of consumer equipment needs and customizations, this is not a realistic expectation in many cases. As such, it makes sense that consumers' old equipment be maintained from both a cost savings and safety perspective.

Recommendation #8: Expand the number of CRT repair facilities in the state that can provide service and repairs for consumers whose equipment is out of warranty.

Currently, in CT, CRT industry must meet manufacturer's standards and be trained properly as well as have an NPI number with CMS to be able to bill for reimbursement. Any new repair facilities would be required to meet these same standards.

An option to consider in this area is having a non-profit option for repair and service. For example, the Oak Hill Center for Assistive Technology - [the New England Assistive Technology NEAT program](#) has the [Adaptive Assistance Reuse program](#), including an entire showroom of sanitized, rebuilt and repaired manual and power wheelchairs, adaptive exercise equipment, pediatric mobility devices, scooters, walkers and more. They also have several rooms of parts and supplies cataloged and available for resell or loan.

Organizations such as this should be considered an option for consumers allowing for more repair technicians available across the state, increased diversity for service allocation and possibly cheaper alternatives. There may be obstacles to this solution in that the entities may not be able to obtain new parts from manufacturers unless they become authorized dealers, there may be conflicts that could interfere with their non-profit mission and they may have infrastructure obstacles. However, this is a resource that may provide some opportunities for collaboration and support that will help address the issues facing consumers with equipment in disrepair.

Recommendation #9: Allow consumers the option to purchase parts from CRT suppliers directly.

We have heard from consumers who prefer, and are able, to fix their own equipment without dealing with insurance and other barriers as cited in this report, but cannot purchase such parts directly from the supplier. Some have stated they go to bike shops, rehab facilities or use old equipment for parts to rig together current equipment and more. The ability to purchase parts directly from the suppliers offers freedom of agency and choice for consumers wishing and able to repair their own equipment with the understanding that manufacturers would need a waiver of liability.

Recommendation #10: CRT suppliers licensed to sell CRT equipment in the State of Connecticut must be required to also provide service and repair.

The CRT industry reports that there are companies in CT contracted by payers that will contract with outside Assistive Technology Professionals to do original equipment assessment and delivery but offer no service or repair. This creates a burden on the consumer who has to then locate a CRT supplier that did NOT sell them their equipment and diverts the CRT suppliers that do sales and repairs away from repairing and servicing the equipment for which they are responsible.

Recommendation #11: Establish a CRT/Wheelchair Advisory Council that meets monthly beginning in August of 2024 with the express goal of monitoring and improving the timelines for repair and service facing the State's CRT consumers when their equipment is in disrepair. The Advisory Council will be required to report to the General Assembly at the start of each session regarding progress on the state of repair and service of CRT.

Recommendation #12: Require Insurance Payment for Overnight or Expedited Delivery of Urgently Needed Parts

When it has been determined that a part is urgently needed to ensure consumer safety, reduce risk of injury or ensure uninterrupted mobility, payers should pay for expedited delivery.

Addendum F: Consumer Advocates Response to Recommendations

The eight Consumer-Advocates on the task force support all twelve recommendations in the report and thank all task force members, particularly the chair, for their extensive contributions over many months. The most important recommendations, in terms of directly reducing delays in getting in-home repairs, are #1 and #4.

Recommendation #1. While we welcome and support the recommendation of an outer limit for the mandated timeline that is less than current in-home service wait times (25-27 calendar days), such an outer limit of less than 10 business days is equivalent to 11-13 calendar days, which would barely be an improvement of pre-COVID wait times (14-21 calendar days). No one whose car needs service would tolerate waiting 11-13 days for an assessment, and then another 11-13 days for a repair after parts have come in. For those of us who are wheelchair users, our safety, independence, and livelihood are on the line when our wheelchairs are broken, and we will never accept such an outer limit as the mandate to be legislated. Therefore, we fervently recommend that both in-home and in-shop assessments and repairs must be conducted by CRT providers within 6 calendar days or 4 business days, after all other processes by third parties are complete. We propose to essentially equalize waits for in-home repairs, where most repairs must occur. Currently, the average wait time as reported by the CRT industry for such **in-shop** visits is 2-4 days.

Our recommendation would also include exceptions to this mandate for customers' scheduling availability or appointment cancellations, or other external factors beyond the CRT industry's control (e.g., severe bad weather). Exceptions, however, would not include instances where the company prioritizes its efficiency concerns over the consumer's scheduling needs, or lacks available staff or vehicles to carry out appointments. There should also be a quicker response for true emergencies, involving immediate risk of injury or "hard down" immobility. Furthermore, we believe the timing of enforcement can be negotiated to allow for adequate preparation by the CRT industry. Gary Gilberti of Numotion said, at the January 25, 2024 task force meeting, "[Consumer-advocate] Jonathan stated he was talking about less than 6 days for an in-person assessment; today that can't happen. You know, if I can hire the [three] people I've committed to hiring, six months from now I might be able to commit to something like that." ([YouTube](#) 56:01-57:07). During the five months of task force meetings, no stakeholder group has suggested an alternative timeline or data-based rebuttal for why this would be logistically impossible, assuming sufficient staff are hired to meet the need in a timely way.

Legislating on this issue and to our recommended degree of 6 calendar days/4 business days has some precedence in a neighboring state. On January 4, 2024, the Massachusetts Senate passed S.2541 which mandates that wheelchair service providers diagnose repair issues remotely within three business days following notice from a consumer or provide an *in-person* assessment *no more than four business days* after, if remote is not possible. While the Massachusetts bill would only apply to repairs that are under warranty, our recommendation, like Recommendation #1 itself, would apply to all wheelchair repair requests, as most consumers depend on their CRT equipment for years beyond the currently mandated 2-year warranty period.

This recommendation is not a mandate for a fixed timeframe for services that depend on other processes outside of the CRT industry's control, but only for the wait time associated with assessment and repair appointments which depend solely on technician availability. According to

NCART's 11/2/23 presentation (see CRT Industry 11/2/23 Presentation, slides 14-17, in the addendum), four general processes need to occur in sequence from the moment a repair is requested to when is completed, each contributing to the total average wait time of 15-90 calendar days:

1. A repair assessment is conducted (2-4 days in-shop/remote, 24-27 days in-home)
2. Insurance prior authorization is obtained (8 days)
3. Parts are received (3-5 days if in-stock, 21-28 days if out-of-stock)
4. The repair is completed (2-4 days in-shop, 25-27 days in-home)

This timeline breakdown reveals that Numotion and NSM are solely responsible for 60-82% of the delay (45-54 days) that consumers experience if they depend on in-home services. When asked if the current backlog could be alleviated by having more technicians available to conduct repair visits, or if orders were still waiting for parts or prior authorization, NSM's representative, Diane Racicot, acknowledged the need for more employees, saying that for "well over two-thirds of our backlog, parts are in, and we are trying to get them out the door" (see minutes of 12/7/23 meeting, at page 3, [YouTube](#) 42:15-42:32). Steps 2 and 3 above are dependent on the insurance policy, manufacturer inventory, and supply-chain efficiency, but our specific timeline recommendation under recommendation #1 only targets steps 1 and 4, recognizing these other matters are outside the CRT's industry's control.

Challenges resulting from the COVID pandemic do not explain the extent of delays in service and communication that consumers have consistently experienced before, during, and after from CRT providers. According to CRT industry's data, the average wait times for in-home assessment and repair appointments were extensive *before* COVID. Wait times for in-home assessments and repair visits then ranged between 14 to 21 days for both steps 1 and 4 mentioned above (see 11/2/23 CRT Industry Presentation, slides 14-17, in the addendum).

At the beginning of the Task Force convening, and as late as November, both companies indicated that they were "fully staffed" (see minutes of 11/2/23 meeting, at page 3, [YouTube](#) 1:08:16-1:08:50), with collectively 16 in-home technicians (8 each) to meet the demand of their 4967 reported wheelchair customers. Eventually, Numotion and NSM acknowledged to the Task Force that additional in-home technicians are the solution to extensive delays; our timeline recommendation would ensure the hiring of an adequate number of technicians, as determined by each company, to provide services to meet it. As noted above, when asked about the root cause of delays in getting backlogged repairs completed, Diane Racicot of NSM said "well over two-thirds" of the delay occurs **after** prior authorization has already been obtained and parts are at the shop waiting for installation. " (see minutes of 12/7/23 meeting, at page 3, [YouTube](#) 42:15-42:32). Similarly, Gary Gilberti of Nuotion said "I get the solution is more people, but that's economically not possible." (see minutes of 11/2/23 meeting, at page 4, [YouTube](#) 1:37:19-1:37:32).

It has only been through pressure by consumers and legislators on the Task Force to address timeliness that Numotion and NSM have opened up collectively 6 new in-home technician positions, 3 each, despite their previous insistence on its impossibility. While this is a welcome, if modest, development, Numotion and NSM have not provided an assessment of the extent to which this would improve in-home service wait times, and much more can and needs to be done.

In addition, based on what has been demonstrated during the spotlight shown on their practices by the convening of the task force, without a legal mandate, both companies would almost certainly revert to their unacceptable lower level of staffing which has prevailed over the last several years, starting long before COVID.

While initially citing various workforce and economic challenges for hiring, the CRT industry eventually also acknowledged that finding and hiring quality technicians is not the issue. Gary Gilberti of Numotion said at the November 2, 2023 meeting, in response to a question from Sen. Seminara about whether there is staff available that can be hired, “yes, there will be, we can get there” and “There are people with skill sets that they can step in and learn some of these things quickly.” (see minutes of 11/2/23 meeting at page 6, [YouTube](#) 1:59:26-2:00:39). The core reasons for staffing difficulties boiled down not to any actual difficulty in hiring but the costs of doing so. When asked pointedly by task force member Rick Famiglietti why they can’t just hire more staff to do repairs in the field, Mr. Gilberti conceded the real reason: “if we added more techs, we added more vehicles, that’s more fuel costs, that’s more other costs that we can’t bear.” (11/16/23 minutes, page 3, [YouTube](#) 46:59-47:33). No financial statements of revenue or actual profits compared to losses from both sales and service were ever provided to the Taskforce to justify the stated economic impossibility of hiring more technicians, despite repeated requests for same.

Numotion and NSM have significant financial capacity to abide by our timeline recommendation and hire the necessary staff, and any internal cost concerns stem from standard cost-cutting practices of private equity (PE) businesses, which are not a necessity but a choice. “Over the last decade, private equity firms have increasingly bought up [Durable Medical Equipment] manufacturers and suppliers and consolidated them, using debt-funded growth strategies to achieve market dominance. The resulting companies are highly indebted, and are now seeking ways to cut costs to achieve the outsized returns demanded by their private equity owners” (see addendum for “Private Equity in DME” Report, 2023, page 7). The same report highlights how the latest owners, AEA Investors for Numotion and Civen for NSM, have bought out 25 and 42 competitors, respectively, across the country since 2013 and have become the dominant wheelchair service providers, while consumer complaints of wait times and litigation surrounding service quality and injuries have only increased (pages 14-15). Having only these two CRT providers, with a total of only three locations and 16 current in-home technicians to serve roughly 5,000 wheelchair users across Connecticut’s 5,543 square miles, is a result of a chosen strategy of market consolidation. Regulating the timeliness and thus the quality of service that CRT providers must provide will not push Numotion and NSM out of any state market that they dominate, such as CT.

Recommendation #4. The CRT industry has consistently touted in-shop services in task force discussions and through its marketing and customer communications as a means of reducing wait times, if *only* more consumers would choose this option. However, the overwhelming majority (about 90%) of Numotion’s and NSM’s customers rely on in-home service for justified reasons; this is not a percentage that will easily change, except out of desperation. For most wheelchair users, even in emergencies, in-home repairs are their **only** option. In order to travel to the shop instead, consumers must overcome several obstacles:

Severity of CRT Breakdown. Because of the current lack of insurance coverage for

preventative maintenance, many wheelchair breakdowns are severe enough to make it impossible or dangerous for consumers to use their equipment at all. They may not be able to leave the house to get into a vehicle for travel, and, in the worst cases, they are bedridden until a repair is completed.

Distance. To reach their CRT provider, many consumers would need to travel easily over 100 miles, an approximately 2-hour round trip, not including additional time for the appointment or traffic. Numotion's only CT shop is located in Rocky Hill. NSM's two shops are in Newington and Niantic.

Means. Many if not most wheelchair users do not drive and do not have access to a private adapted vehicle. Most are of very limited financial means. No insurance currently covers transportation to wheelchair repair visits -- only appointments for fitting and measuring consumers or for a new wheelchair or CRT device. Only if recommendation #5 is implemented will this be covered, but only for Medicaid enrollees. Existing programs that supplement out-of-pocket taxi costs are only practical for much shorter distances.

Time. The disruption of having to travel several hours for a single appointment can be extremely burdensome and prohibitive. Wheelchair users already require significantly more time and energy, in general, to manage activities of daily living, family, school, and work compared to non-wheelchair users, who would also undoubtedly avoid such lengthy trips for routine necessities if avoidable.

Safety. Almost every wheelchair repair requires the consumer to transfer out of the broken device and onto another surface at a similar height, such as a mat, bed, couch, or other wheelchair. Currently, in-shop service locations do not have the necessary Hoyer lifts, height-adjustable transfer tables, loaner chairs, or certified staff necessary and authorized to assist consumers in transferring out of their broken wheelchairs. Additionally, if consumers have a backup wheelchair to use temporarily, they may not be allowed to bring it along with their broken wheelchair when using transportation services and may have difficulty in transporting them even in their private vehicles. To transfer safely, consumers may need caregivers to accompany them, adding logistical complexity but also additional risks if caregivers do not have access to assistive devices such as lifts that may be available in their client's home.

Despite the resulting clear need for timely in-home services in the vast majority of cases, the CRT industry has repeatedly claimed "to ask us to get to an in-shop and an in-home repair time period that matches is not feasible, and it's not feasible because it doesn't exist in any other industry anywhere ... it also disincentivizes people who, who, you know, why would you come into the shop to get a repair when we can come to your home?" (see minutes for 1/25/24 meeting, [YouTube](#), 54:50-55:12). The availability of numerous same-day roadside or driveway services for vehicle repairs demonstrates that similar services *are* provided in other industries, and *used to be* in Connecticut for CRT when the industry was run by local (non-private equity) companies, and for similar reasons: traveling into a shop may be dangerous if not impossible for the driver. We recognize that in-shop services undoubtedly could provide the most immediate option for emergencies – in those minority of cases where consumers can travel and sacrifice other

Addendum G: CRT Industry Response to Recommendations

Recommendation #1 - Timeline

1. The consumers and the industry agree that we all want more timely repairs. The consumers have repeatedly stated they want the same timeline for repairs, whether this is in-shop or in the home. This is not achievable in any business operating in any industry. Such a requirement would give consumers the incentive to demand in-home repairs for all repairs and would further exacerbate the current situation. Why would you want to go to the service location when you can get the service in your home within the same period?
2. The industry cannot provide deadlines for in-home assessments or repairs. We have repeatedly stated that there are too many variables that are unknown and that cannot be factored into the timelines. At this point, there are more unknown variables than known. We have offered reasonable deadlines for remote assessment and in-the-shop repair times.
3. The industry will not agree to penalties of any kind. We have shown our commitment by being active participants in the process along with investing in additional technicians and customer service staff with no guarantee that reimbursement being discussed for travel will be included in the final legislation. We are still working our way through the backlog and committing additional resources to quicken the reduction in outstanding repairs.
4. We felt that the purpose of this task force was to understand the issue with repairs and service and offer solutions to shorten the timelines. The proposed penalties do nothing to shorten the timelines- they are there to punish industry members.
 - a. Recommendation #11, which would create a CRT advisory council, is the proper way to ensure that all stakeholders are working to fix the issue and can provide assurances to legislators through the monthly reporting that the task force and the legislation developed are successful.
5. The idea was offered to include timelines to begin at a certain period in the future. We do not know what will happen in the future. We are now dealing with a potential delay in parts for ships traveling through the Panama Canal due to low water levels. Nobody could predict this issue because we don't know what will happen.
6. Please clarify that it is ten (10) business days.

Recommendation #2- Eliminate prior authorization

1. The industry supports this recommendation as written. We want to point out that the Massachusetts legislation eliminates prior authorization on repairs for all insurance companies and does not limit this to Medicaid only.

Recommendation #3- Annual preventative maintenance

1. The industry supports this recommendation as written. Iowa, Tennessee, and Pennsylvania, pending legislation, include preventative maintenance.

Recommendation #4- Consumers must be offered and provided in-home repairs

1. The industry supports this recommendation as written.

Recommendation #5- Transportation to the CRT location should be a covered benefit

1. The industry agrees to this recommendation. We would ask that the reference that the reference to transportation being cost-prohibitive for Medicare patients be removed. The Medicare program is not an income-based system, so to include them would not be indicative of the income demographic of the average Medicare consumer. The statement says that non-medical transportation covers doctor visits but is not equipped to handle wheelchairs; how are consumers in wheelchairs getting to their doctors' appointments?

Recommendation #6- Payers will cover repair technician travel to the consumer's location

1. The industry agrees to this recommendation. We would ask the statement (sentence 3) “and should continue to be performed in the home” be revised to “and should continue to be offered in the home”.

Recommendation #7- Annual preventative maintenance to consumer-owned backup equipment should be a covered benefit

1. The industry agrees with this recommendation as written. The state of Massachusetts has recently begun covering this benefit.

Recommendation #8- Expand the number of repair facilities in the state for consumers

1. The industry agrees with this recommendation as written.

Recommendation #9- Allow consumers to purchase parts directly from CRT Suppliers

1. The industry agrees with this recommendation.
 - a. We must inform the legislators that some contracts with insurance companies and Medicaid prohibit consumers from paying for parts or repairs.
 - b. The liability waiver would need to cover both the manufacturers and suppliers.

Recommendation #10- CRT suppliers licensed to sell CRT equipment in the state of Connecticut must also be required to provide service and repair

1. The industry agrees with this recommendation.
 - a. We ask that you consider adding the verbiage “Any supplier operating in the state of Connecticut providing CRT or mobility equipment to any Connecticut consumer.”

Recommendation #11- Establish a CRT advisory council that meets monthly

1. The industry agrees with this recommendation.
 - a. We recommend that the advisory council be made up of a cross-section of industry stakeholders.
 - b. We recommend that the advisory council create metrics the stakeholders agree on, which shall be reported to the agencies.

Recommendation #12- Require insurance payment for overnight delivery

1. The industry agrees with this recommendation as written.

Addendum H: Insurance Industry Response to Recommendations



Connecticut Association of Health Plans Wheelchair Repair Task Force Recommendation Comments

On behalf of the Connecticut Association of Health Plans (CTAHP), I'd like to commend the dedication of all members of Wheelchair Repair Task Force and formally recognize the serious nature of the frustrations and challenges presented by consumer advocates. I'd also like to acknowledge the exemplary work of Bev Brakeman in managing and guiding the task force during the past several months.

Task force discussions, in and of themselves, appear to have yielded important process changes within the industry already and established a much-needed open line of communication between, and amongst, the various stakeholders such that sweeping legislative changes may be unnecessary.

While many of the task force's recommendations are laudable in intent, most are also interdependent on other variables outside the purview of the task force including, but not limited to, supply chain and workforce issues as well as budget and resource allocations. These factors require consideration of the recommendations within a much broader context and scope.

Within that broadened scope is the fiscal impact that new regulatory mandates pose for commercial policyholders in Connecticut. Commercial insureds, subject to state regulatory authority, represent only 13% of the state's total population. These enrollees, including individuals on the Exchange, are among the most price sensitive in the health insurance market and are therefore the least able to bear the additional costs of new state benefit mandates. Furthermore, task force deliberations seem to point towards supply chain and workforce issues as the predominant factors in delay of repair as opposed to the insurance related requirements like prior authorization. CTAHP therefore respectfully opposes any of the proposed insurance mandates within the task force report.

With respect to the various purchase option recommendations under consideration, CTAHP underscores the importance to consumers of utilizing in-network provider entities in order to maximize the coverage provided by their insurance carrier.

Thank you for the opportunity to comment.

Susan J. Halpin

*Executive Director
Connecticut Association of Health Plans*

Addendum I: DSS Response to Recommendations

Recommendation #1: Agreed, however establishing enforcement and penalty measures for non-compliance would not be within DSS' authority.

Recommendation #2: DSS recommends not eliminating the prescription requirement for repairs of CRT equipment. Rather, DSS recommends allowing the original custom wheelchair prescription to include all needed repairs for the lifetime of the wheelchair (which is typically 5 years or more).

DSS does not recommend eliminating PA from all repairs over \$1000. Prior Authorization (PA) is an important tool to maximize Medicaid resources. Unlike Massachusetts which requires prior authorization (PA) for repairs totaling over \$1000, the current process in Connecticut is that PA threshold is reviewed on an individual procedure code level. The Department is requesting additional time to look at the procedure codes requiring PA for repairs and provide recommendations as to which procedure codes DSS should remove PA from.

Recommendation #3: Currently DSS does not provide annual preventative maintenance for CRT equipment. The Department anticipates this will result in significant expenditures to the Medicaid Program. The Department would have to determine the fiscal impact and based on the estimated increase to expenditures, consider the trade-offs within the context of other budget demands likely to be raised during budget negotiations and, depending on the outcome of such consideration, request additional funding through the budget process.

Recommendation #4: DSS agrees consumers should be offered and provided timely in-home repairs.

Recommendation #5: Even if the current Regulations of Connecticut State Agencies were changed, The Department will not support this recommendation, due to the following:

- High risk of member injury in the process of transport;
- NEMT vendors would not contractually agree to transport members with malfunctioning, compromised wheelchairs to repair facilities due to high risk of possible injuries to Members and legal liability concerns;
- The Department would have to determine the fiscal impact of adding appropriate coverage for NEMT for wheelchair repairs and receive OPM approval based on the estimated increase to expenditures, consider the trade-offs within the context of other budget demands likely to be raised during budget negotiations and, depending on the outcome of such consideration, request additional funding through the budget process.

Recommendation #6: DSS has researched reimbursement for travel time and in the Regulations of Connecticut State agencies Section 17b-262-680 (c) Payment Limitations states that "The price for any item listed in the fee schedule published by the department shall include: (1) fees for initial fittings and adjustments and related transportation costs; (2) labor charges; (3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping; (4) travel to the client's home, postage and handling, and set up or installation charges; (5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the equipment; and (6) information furnished by the provider to the client over the telephone. Any reimbursement rate updates would require a fiscal impact and

DSS would need to receive OPM approval based on the estimated increase to expenditures, consider the trade-offs within the context of other budget demands likely to be raised during budget negotiations and, depending on the outcome of such consideration, request additional funding through the budget process.

Recommendation #7: Currently, DSS does not have an established policy to provide preventative maintenance for HUSKY members' backup equipment (wheelchairs).

First, the DSS would have to determine the fiscal impact and, based on the estimated increase to expenditures, consider the trade-offs within the context of other budget demands likely to be raised during budget negotiations and, depending on the outcome of such consideration, request additional funding through the budget process.

Second, systems changes would need to be made in order for DSS to be able to distinguish between repairs of new wheelchairs and repairs to back-up wheelchairs. This will be a lengthy process as all the different procedure codes will need to be identified. Third, DSS recommends that each individual wheelchair have their own assigned prescription on file (could not use the same prescription for two different wheelchairs). Fourth, per Section 17b-262-677 of the Regulations of Connecticut State Agencies, "The Department shall not pay DME providers for...(2) the purchase or repair of DME necessitated by inappropriate, willful, or malicious misuse on the part of the client as determined by the department." DME vendors would have to abide by this.

Fifth, per Section 17b-262-680 (b) of the Regulations of Connecticut State Agencies: "If the cost of repairs to any item exceeds its replacement cost, the item shall be replaced." DME vendors would need to understand that the Department will not be providing back-up equipment but rather, once the original custom wheelchair becomes older than five years, then that original wheelchair could be considered back-up equipment (if the Department determines it should be maintained).

Recommendation #8: DSS cannot take a position in support or opposition of this particular recommendation.

Recommendation #9: DSS has concerns with this recommendation. Per federal regulations, DSS cannot provide reimbursement directly to HUSKY members for incurred expenses for Medicaid eligible services. Per Section 17b-262-531 of the Regulations of Connecticut State Agencies: "(e) the department shall make payment only to a duly enrolled provider" and "(j) a provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, or any portion of the costs of goods or services which are covered and payable under the Connecticut Medical Assistance Program. If a client or representative has paid for the goods or services...payment made by or on behalf of the client shall be refunded by the provider to the payer. The provider then may bill the medical assistance program for goods or services provided."

Members must work with Medicaid-enrolled providers to obtain DME items and prescriptions are required for all DME items. Only a Medicaid-enrolled DME vendor can submit a claim to the Department for covered items/services.

Recommendation #10: DSS supports this particular recommendation.

Recommendation #11: DSS acknowledges the importance of this recommendation, however, DSS cannot commit to meeting on a monthly basis as the department is tasked with overseeing the entirety of the Medicaid program.

Recommendation #12: DSS cannot support this particular recommendation. The Regulations of Connecticut State agencies Section 17b-262-680 (c) Payment Limitations states that “The price for any item listed in the fee schedule published by the department shall include: (1) fees for initial fittings and adjustments and related transportation costs; (2) labor charges; (3) delivery costs, fully prepaid by the provider, including any and all manufacturer’s delivery charges with no additional charges to be made for packing or shipping; (4) travel to the client’s home, postage and handling, and set up or installation charges; (5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the equipment; and (6) information furnished by the provider to the client over the telephone.

The Department believes this would create a significant fiscal impact as this reimbursement would need to apply to other type of urgently needed DME. DSS will need to request OPM approval based on the estimated increase to expenditures, consider the trade-offs within the context of other budget demands likely to be raised during budget negotiations and, depending on the outcome of such consideration, request additional funding through the budget process.