



CMCS Informational Bulletin

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SUBJECT: **Medicare Competitive Bidding Program for Durable Medical Equipment and Coordination of Benefits for Beneficiaries Eligible for Medicare and Medicaid (Dual Eligibles)**

This Informational Bulletin provides information for state Medicaid agencies and other interested parties about Medicare's Competitive Bidding Program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). In most cases under this program, Medicare will only pay contract suppliers to furnish certain DMEPOS to beneficiaries with Original Medicare, including dual eligibles, in competitive bidding areas (CBAs). These dual eligible beneficiaries are not enrolled in any Medicare Advantage plan, but may be enrolled in Medicaid Managed Care Organizations (MCOs). The Bulletin discusses Medicaid coverage for Medicare cost-sharing amounts for DMEPOS for dual eligibles and Medicaid enrollment of Medicare contract suppliers, including those providers located in another state.

Medicare Competitive Bidding Program for DMEPOS: Background

Beginning July 1, 2013, Medicare expanded its competitive bidding program for DMEPOS to more areas of the country. This program changes the amount Medicare pays for certain DMEPOS and makes changes as to which suppliers Medicare will pay to provide these items.

The DMEPOS Competitive Bidding Program applies to beneficiaries with Original Medicare whose permanent residence is in a zip code that is part of a CBA or who obtain competitively bid items while visiting a CBA. These individuals will need to obtain their equipment and supplies from a Medicare contract supplier in order for Medicare to help pay for the items unless an exception applies.

Round 1 of the program began on January 1, 2011 and is in effect in certain zip codes in these states: California, Florida, Indiana, Kansas, Kentucky, Missouri, North Carolina, Ohio, Pennsylvania, South Carolina and Texas.

A complete list of the areas included in Round 2 of the program is available at <http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/DMEPOSBenefactSheetMarch2013.pdf>.

Obtaining Competitively Bid DMEPOS from Contract Suppliers

A contract supplier must agree to furnish covered items under its contract to any beneficiary who maintains a permanent residence in or visits a competitive bidding area and requests those items from the contract supplier. The only exception to this rule is a skilled nursing facility or nursing facility that has been awarded a contract as a specialty supplier. A specialty supplier may furnish contract items to its own residents only.

Contract suppliers can't refuse to furnish Medicare-covered DMEPOS items that are in their contracts. They are not eligible for Medicare payment for competitively bid items that aren't in their contracts unless there is an exception.

Obtaining Other DMEPOS

Non-competitively bid items can be furnished by any Medicare-enrolled supplier that is qualified to furnish them. There is no requirement for a beneficiary to have any interaction with a contract supplier for a non-competitively bid item; the beneficiary can simply go to any Medicare-enrolled supplier.

National Mail-Order Program for Diabetic Testing Supplies

Medicare implemented a national mail-order program for diabetic testing supplies on July 1, 2013. Beneficiaries with Original Medicare will need to use a Medicare national mail-order contract supplier for Medicare to pay for diabetic testing supplies that are delivered to their homes. If beneficiaries don't want their diabetic testing supplies delivered to their home, they can go to any local store (local pharmacy or storefront supplier) that's enrolled with Medicare and buy them there.

DMEPOS Included in Round 2 of the Program

The categories of items and services included in Round 2 of the program are:

1. Oxygen, oxygen equipment, and supplies
2. Standard (power and manual) wheelchairs, scooters, and related accessories
3. Enteral nutrients, equipment, and supplies
4. Continuous Positive Airway Pressure (CPAP) devices, Respiratory Assist Devices (RADs) and related supplies and accessories
5. Hospital beds and related accessories
6. Walkers and related accessories
7. Negative Pressure Wound Therapy (NPWT) pumps and related supplies and accessories
8. Support surfaces (Group 2 mattresses and overlays)

Beneficiaries in Round 2 CBAs who were renting certain medical equipment or receiving oxygen or oxygen equipment on July 1, 2013 may have the choice to stay with their current supplier even if the

supplier does not have a contract with Medicare. A non-contract supplier can choose to become a “grandfathered” supplier and continue to rent items to a Medicare beneficiary who permanently lives in a CBA if the non-contract supplier was renting the item to the beneficiary at the time the competitive bidding program was implemented. Grandfathered suppliers may not furnish competitively bid items to new Medicare beneficiaries in Round 2 CBAs after July 1, 2013 unless there is another applicable exception.

Dual Eligibles: Coordination of Medicare and Medicaid Coverage

All Original Medicare beneficiaries who also have Medicaid coverage and who live in a CBA will have to get competitively bid DMEPOS from a Medicare contract supplier or a “grandfathered” supplier in most cases. The principles that apply to obtaining competitively bid DMEPOS in a CBA also apply to Original Medicare beneficiaries who are enrolled in MCOs, if the state Medicaid program pays the MCO a capitation rate that includes MCO payment of Medicare cost-sharing amounts.

Medicare CBAs may include zip codes in more than one state. In this situation, while the DMEPOS may come from an out-of-state provider, the DMEPOS is actually being furnished in-state and the provisions of 42 CFR 431.52 that limit payment to out-of-state providers don’t apply.

Medicare Cost-Sharing Amounts and Medicaid State Plan-Covered Services Not Covered by Medicare

Medicaid will pay the cost-sharing amounts (deductibles and coinsurance) for these services according to the currently approved Medicare cost-sharing payment methodology in the Medicaid State Plan. Dual eligibles are responsible for payment of required nominal Medicaid co-payments, if applicable to the DMEPOS provided.

Qualified Medicare Beneficiary (QMB) and QMB Plus Dual Eligibles

- For the QMB only, Medicaid pays Medicare cost-sharing amounts only. If Medicare denies payment, Medicaid will not pay for the DMEPOS.
- For QMB Plus, Medicaid will pay Medicare cost-sharing amounts for Medicare-covered DMEPOS. If Medicare doesn’t cover the DMEPOS, but the Medicaid state plan does, Medicaid will pay for the DMEPOS, subject to limitations established in the state plan, when the beneficiary obtains the item or service from a Medicaid-participating provider.
- Providers are strictly prohibited under section 1902(n)(3) of the Social Security Act from seeking to collect any amount from the QMB or QMB Plus beneficiary for Medicare deductibles or coinsurance (other than nominal co-payments under Medicaid, if applicable), even if the Medicaid program’s payment is less than the total amount of the Medicare deductibles and coinsurance.

Specified Low-Income Beneficiary (SLMB) Plus, and Full Benefit Dual Eligible (FBDE) Beneficiaries

If Medicare doesn't cover the DMEPOS, but the Medicaid state plan does, Medicaid will pay for the DMEPOS, subject to limitations established in the state plan, when the beneficiary obtains the item or service from a Medicaid-participating provider.

Medicaid enrollment of Medicare contract suppliers

The state may require Medicare contract suppliers to execute a Medicaid provider agreement and enroll in the state's Medicaid program in order to submit claims for reimbursement of DMEPOS cost sharing, but the state should have a mechanism to ensure that providers who enroll only for that purpose are not included in a list of providers available to other beneficiaries. Alternately, a state may utilize a simplified, limited-purpose enrollment process for these providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement while in compliance with the provider screening and enrollment requirements included in the CMCS Informational Bulletin issued December 23, 2011 (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf>).

Regardless of the specific enrollment mechanism chosen, states must enable all Medicare contract suppliers who serve QMB or QMB Plus beneficiaries for a CBA, including those who are out-of-state, some mechanism by which they can get the state to process their Medicare crossover claims for services provided to those beneficiaries, including claims for DMEPOS cost sharing.

Additional Information Is Available

For more information about Medicare's DMEPOS Competitive Bidding Program, please visit http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html.

A Medicare beneficiary who has any questions related to acquiring DMEPOS if he or she lives in a CBA, including how to find a contract supplier, should visit www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048.

If you have any further questions about coordination of Medicare and Medicaid coverage for dual eligibles, please contact Cathy Sturgill, Health Insurance Specialist, at 410-786-3345 or Cathy.Sturgill@cms.hhs.gov.