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CMCS Informational Bulletin

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SUBJECT: Strategies to Support Dual Eligible Beneficiaries' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The purpose of this Informational Bulletin is to provide examples of effective strategies for states to better support timely access to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for beneficiaries dually eligible for Medicaid and Medicare ("Medicare-Medicaid enrollees" or "dual eligible beneficiaries"). Both Medicare and Medicaid cover DMEPOS, which can be essential to Medicare-Medicaid enrollees' mobility, health status, independence in the community, and overall quality of life. However, the programs' different eligibility, coverage, and supplier rules can impact access to medically appropriate DMEPOS and repairs of existing equipment for the population enrolled in both benefits. This Informational Bulletin describes strategies to promote timely access to needed DMEPOS while fulfilling states' obligations to ensure Medicaid is payer of last resort.

Background

According to stakeholders,[1] a common barrier to DMEPOS access stems from conflicting approval processes among Medicare and Medicaid that can leave suppliers uncertain about whether and how either program will cover items. Because suppliers lack assurance regarding how Medicare or Medicaid will cover DMEPOS at the point of sale[2] – and dual eligible beneficiaries (the majority of whom have incomes under 100 percent of the federal poverty level) generally cannot afford to pay out-of-pocket up front – suppliers may refuse to provide needed DMEPOS.

Medicare is the primary payer for DMEPOS and other medical benefits covered by both programs, but limits DME to use in the home. Medicare generally only processes claims after the

[1] See 2016 responses to Request for Comment on Access to DME (https://www.regulations.gov/docket?D=CMS-2016-0107) and 2011 comments submitted in response to Federal Register Request for Comment on Opportunities for Alignment under Medicaid and Medicare (http://www.regulations.gov/docket?dct=FR%25252BPR%25252BN%25252BO%25252BSR%25252BPS&rpp=25&po=0&D=CMS-2011-0080)

[2] See 2013 CMCS Informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-08-02-2013.pdf

equipment is delivered. Many of the Medicare requirements related to DMEPOS, including the definition and scope of the benefits, are mandated by federal statute.

Medicaid typically covers Medicare cost-sharing amounts and may cover DMEPOS that Medicare does not, including certain specialized equipment that promotes independent living outside the home. Section 1902(a)(25) of the Social Security Act (the Act) requires each state, under its State Medicaid Plan, to take all reasonable measures to ensure that other payers pay to the limit of their legal liability before any Medicaid payment is available. Therefore, Medicaid pays secondary to most other legally liable payers, including Medicare.

The strategies below address ways states can address the barriers described above while still ensuring they meeting obligations to be payer of last resort.

Offer Medicaid Prior Authorization of DMEPOS for Dual Eligible Beneficiaries

CMS encourages states to offer a process for suppliers to request prior authorization of more costly DMEPOS for dual eligible beneficiaries. Many states have already instituted Medicaid prior authorization processes, but often exclude dual eligible beneficiaries, or require a Medicare denial first before Medicaid prior authorization can be requested. As noted above, suppliers may be unwilling to deliver an item if the provider is uncertain whether the beneficiary meets Medicare coverage criteria. One strategy used by some states is to prior authorize an item but still require a supplier to submit the claim to Medicare first and obtain a denial before submitting to Medicaid for payment. This provides suppliers with confidence of Medicaid payment if the Medicare claim is denied and promotes more timely delivery of needed DMEPOS.

Ensure DMEPOS Claims for Dual Eligible Beneficiaries are Assessed against Medicaid's Broader Criteria

On February 2, 2016, CMS issued updated regulations at 42 CFR §440.70 codifying long-standing policy that Medicaid must cover appropriate medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, other than inpatient settings. In other words, coverage cannot be limited to the home setting, as long as the other coverage requirements are met. The regulation[3] was effective July 1, 2016 but will take effect in certain states up to two years later, depending on state legislative cycles.

The regulation means that Medicaid may not use Medicare coverage as a complete proxy for Medicaid coverage of medical supplies, equipment and appliances for dual eligible beneficiaries. As noted above, Medicaid coverage of medical supplies, equipment and appliances is broader than Medicare's, so it is critical that states assess claims for medical supplies, equipment, and appliances for dual eligible beneficiaries against these broader criteria.

Medicare Prior Authorizations

If a supplier requests Medicare prior authorization, a non-affirmed prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage.

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[3] See regulation: https://www.federalregister.gov/documents/2016/02/02/2016-01585/medicaid-program-face-to-face-requirements-for-home-health-services-policy-changes-and

The scope of the Medicare prior authorization program for DMEPOS has been limited to date. On September 1, 2012, CMS began the Prior Authorization of Power Mobility Devices (PMDs) Demonstration. The demonstration is currently active in 19 states and will continue through August 31, 2018. The DMEPOS codes for which prior authorization applies may be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/PADemo.html.

More recently, CMS issued a new regulation that establishes a prior authorization process for certain DMEPOS items subject to unnecessary utilization. See 42 CFR § 414.234. This regulation became effective on February 29, 2016. In the federal register published on December 19, 2016, CMS announced the selection of two items of durable medical equipment to be subject to required prior authorization in Illinois, Missouri, New York, and West Virginia beginning on March 19, 2017:

- K0856: Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0861: Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

CMS also announced its intent to expand the prior authorization process for codes K0856 and K0861 nationwide in July 2017. Further information on these codes can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html. Please refer to this same link for any future updates.

States should be careful to only require a Medicare non-affirmed prior authorization decision for the specific items for which Medicare offers prior authorization. For example, in the Power Mobility Device demonstration, prior authorization is not offered for Group 4 wheelchairs, as they are excluded from Medicare coverage itself by Local Coverage Determination L33789.

Applying These Strategies to Medicaid Managed Care Organizations (MCOs)

States should consider incorporating these requirements and strategies into their contracts with Medicaid MCOs, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) when contracting with them to deliver Medicaid DMEPOS to dual eligible beneficiaries.

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