DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SMD# 17-006

RE: Limit on Federal Financial Participation for Durable Medical Equipment in Medicaid

December 27, 2017

Dear State Medicaid Director:

Through passage of section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, Congress added section 1903(i)(27) to the Social Security Act (the Act) which prohibits federal Medicaid reimbursement to states for certain durable medical equipment (DME) expenditures that are, in the aggregate, in excess of what Medicare would have paid for such items. The requirement takes effect January 1, 2018.

This new statutory provision does not necessitate that CMS promulgate new regulations because it can be implemented under existing authorities applicable to state reporting requirements set forth in section 1902(a)(6) of the Act and regulations at 42 C.F.R. § 431.16. This letter presents general information on the new provision, describes the options available to states to demonstrate compliance, and provides technical information to facilitate the states' calculation of the expenditures subject to the limit on federal financial participation (FFP).

Requirements of Section 1903(i)(27) of the Act

In general, section 1903(i)(27) of the Act provides that federal Medicaid reimbursement to states shall not be made with respect to any amounts expended by a state on the basis of a fee schedule for DME items under Medicare detailed in section 1861(n) of the Act and furnished on or after January 1, 2018, that exceeds certain aggregate limits. A state's Medicaid expenditures for DME items that are subject to this provision will be determined in the aggregate and expenditures in excess of what Medicare would have paid for such items in the aggregate, either on a fee schedule basis or under its competitive bidding process, are not eligible for FFP.[1] The statute

[1] Section 503(a)(1) of the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 (2015), added language to the Medicaid Act that prohibits payment of Federal matching funds. Specifically, the statute provides:

> [Payment under the preceding provisions of this section shall not be made—]
> (27) with respect to any amounts expended by the state on the basis of a fee schedule for items described in section 1861(n) and furnished on or after January 1, 2019, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII, including, as applicable, under a competitive acquisition program under section 1847 in an area of the state.

goes on to state that the new provision does not in any way prohibit a state Medicaid program from providing DME items for which payment is denied or not available under the Medicare program.

DME items not subject to the limitation

Not all Medicaid expenditures for DME are subject to this provision. The FFP limitation imposed by section 1903(i)(27) of the Act applies only with respect to those items of DME covered by a state's Medicaid program that are also covered by Medicare. Items covered as DME by only one of the programs are not included. Therefore, this limit does not apply to prosthetics, orthotics, or medical supplies, which are not included in the definition of DME under the Act. Likewise, section 1903(i)(27) of the Act does not limit federal matching payments for items of DME that are covered under the state Medicaid plan but for which payment is not allowed under the Medicare program. This statutory limitation also does not apply to items for which Medicaid is not the primary payer.

Also, only those items provided in the Medicaid program on a fee-for-service basis are to be included in the aggregate expenditure calculation. DME reimbursed under a Medicaid managed care arrangement or a Medicaid competitive bidding contract are not subject to the FFP limitation. Medical equipment and appliances that are provided in an institutional setting such as a hospital or nursing home and paid as a component of the institutional payment, are not subject to this FFP limitation. However, any DME items that are provided to a Medicaid beneficiary in an institutional setting but paid on a fee-for-service basis separate from the institutional payment will be subject to the FFP limit requirements.

DME under Medicare and Medicaid

Coverage and payment rules for DME under Medicare differ from those implemented by states under Medicaid. In order to understand how states will calculate and apply the FFP limit mandated by the statute, it is important to understand some basic differences in the DME rules under the two programs.

Medicare DME is a Part B benefit category.[2] The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home whether furnished on a rental basis or purchased. Medicare regulation at 42 C.F.R. § 414.202 further defines DME as equipment furnished by a supplier or a home health agency that can withstand repeated use, effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years, is primarily and customarily used to serve a medical purpose,

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Subsequently, in section 5002 of the 21st Century Cures Act, Pub. L. No. 114-255 (2016), Congress altered the effective date to make this provision effective on January 1, 2018.

[2] DME is covered by Medicare based, in part, upon section 1832(a) of the Act, which describes the scope of benefits under the supplementary medical insurance program (Medicare Part B), to include ''medical and other health services,'' which is further defined under section 1861(s)(6) of the Act to include DME. In addition, section 1861(m)(5) of the Act specifically includes DME in the definition of the term "home health services."

generally is not useful to an individual in the absence of an illness or injury, and is appropriate for use in the home.

For purposes of this letter, the rates for Medicare DME under the Part B benefit are set using two separate methods. First, the payment amount for an item may be based on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule rates for rural and non-rural areas in each state, published on the CMS website.[3] Alternatively, the payment amount for an item may be based on the competitively bid rate for certain items established under Medicare's competitive acquisition program if the item is furnished in one of the competitive bidding areas (CBAs) that have been established in certain metropolitan services areas (MSAs).[4]

In Medicaid, medical supplies, equipment and appliances are a mandatory benefit authorized by section 1905(a)(7) of the Act under home health services and implemented by 42 C.F.R. §440.70(b)(3). Section 1905(a)(11) of the Act and 42 C.F.R. §440.110 authorize coverage and payment also for certain supplies and equipment used during physical, occupational, and speech/language therapy. The Act does not specify a list of medical equipment and appliances that are allowable in the Medicaid program. Medicaid equipment and appliances covered under the home health services or physical, occupational, and speech/language therapy encompass the Medicaid items that we consider to be analogous to the items of Medicare DME and subject to this limit.

Further, federal regulations at 42 C.F.R. §440.70(b)(3) provide that state Medicaid coverage of equipment and appliances is provided on a case-by-case basis. This coverage is not restricted to the items covered as DME in the Medicare program. Moreover, federal regulations at 42 C.F.R. §440.70(b)(3)(v) indicate that states can have a list of preapproved medical equipment supplies and appliances for administrative ease but states are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances.

Medicaid payment for DME items is usually made on either a fee schedule basis, through a managed care contract for enrolled individuals, or under a competitive bidding arrangement of the state's design.

State options to demonstrate compliance with the FFP limit

There are two basic options available to states to demonstrate that their expenditures for DME items subject to this provision do not exceed the amount for which FFP is available. The simplest way is for the state to base its Medicaid DME payment rates on Medicare's fee schedule or

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[3] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

[4] Under the program, suppliers submit a bid to furnish a competitive bid item in a competitive bidding area (CBA). There have been two rounds of the phase in of competitive bidding areas thus far, plus implementation of a national mail order program for diabetic supplies, which have been recompeted. In round one, there are nine MSAs and in round two, there are over 90 MSAs selected to participate in the CBP. The MSAs were selected based on the volume of DME items, the number of suppliers, the number of beneficiaries within the defined areas, or as specifically mandated by section 1847(a)(1)(D)(ii)(II) of the Act. The three largest MSAs for New York, Los Angeles and Chicago were subdivided into 12 competitive bidding areas. In addition, multi-state MSAs were divided into state-specific competitive bidding areas.

competitive bid rates or on a lesser percentage thereof. Another option is for the state to conduct a robust comparison using both rate and unit utilization data to calculate what would have been the aggregate reimbursement under Medicare for those same items in order to demonstrate that the state payments are less than the allowable amount described in the statute. We would also consider alternative approaches that will meet a state's specific needs provided that such approaches are sufficient to ensure compliance with section 1903(i)(27) of the Act.

State Plan rates established at or below Medicare rates

There are a number of states that currently use the Medicare payment rates, or some percentage of those payment rates, for Medicaid reimbursement of some or all Medicaid DME. Where a state can ensure that all items of DME subject to the FFP limitation are reimbursed at or below Medicare's prevailing payment rates as described on the DMEPOS fee schedule or under the Medicare CBP the aggregate, Medicaid expenditures cannot exceed what Medicare would have paid for the same items.

If the state does not currently use Medicare's payment rates (or a lesser percentage thereof) to reimburse providers for DME, the state may submit a state plan amendment to alter its DME reimbursement methodology to set rates at or below the applicable Medicare rates. If there are CBAs in the state as defined by Medicare, it may choose to either pay the competitive bidding single payment amount for DME in the applicable CBA of the state under the Medicare program, or could set the statewide plan rate at the lesser of the DMEPOS fee schedule rate, including rural and non-rural areas as defined by Medicare, or the competitive bid single payment amount under the Medicare CBA for the item. Examples of model state plan language are included in the technical appendices that accompany this letter.

Because this is an annual aggregate limit of FFP as relative to the Medicare payment amounts, any state payment methodology which sets rates at or some percentage below the Medicare payment amounts to demonstrate compliance with the statute must also account for changes to the Medicare payment amounts under the Part B benefit and under the CBP in order to continue to remain compliant with the statute from year-to-year. This may include changes to the number of CBAs under the Medicare CBP, as well as changes in the Medicare payment rates. This would require a state to review Medicare payments as they are published and be aware of any changes to the CBAs which affect the state.

Medicare DME aggregate payment comparison

If the state does not use Medicare's rates for DME reimbursement under the approved state plan for the DME items subject to this provision using payment amounts that are at or below the Medicare rates, the state will need to conduct a comparison of the aggregate amounts expended by the state Medicaid program for DME furnished after January 1, 2018 to the aggregate amount which would be paid for such items on a fee-for-service basis under Medicare Part B, including, as applicable, under a competitive acquisition program under section 1847 of the Act in an area of the state.

To determine the aggregate limit, states will first identify the DME items that are covered under its program and are subject to the limit. Typically, this will include DME items that are identified

by Healthcare Common Procedure Codes (HCPCS) E series and K series of codes. The calculation will also include items within the A series of HCPCS codes that meet the Medicare definition of DME. The applicable Medicare payment amount for each item of DME would then be multiplied by the units reimbursed by the state Medicaid program and totaled in order to establish the limit on available Medicaid FFP. The statute is specific in its inclusion of both the Medicare fee-for-service rates (the DMEPOS fee schedule) and the single payment amounts that are set under a competitive acquisition program in designated MSAs within the state.

Information related to CBAs, MSAs, Medicare rates and other source data required for this method of comparative calculation is included in the appendices to this letter.

State actions required

States are advised to work with CMS to determine their method of ensuring compliance with the statute. Any communication related to the policy outlined in this letter should be sent to the CMS regional office and MedicaidDME@cms.hhs.gov.

If the state is ensuring that the FFP limit cannot be exceeded because the state uses Medicare's rates (or a lesser percentage thereof), the state will be required to communicate that to CMS and supply the approved Medicaid state plan page which authorizes those payment amounts. Upon review of this information, CMS may request a state to amend their state plan to mirror the language outlined in the appendices of this letter to ensure that the state plan language is consistent with the statute.

If the state chooses to comply with section 1903(i)(27) of the Act by changing their Medicaid state plan DME payment methodology to pay at or a lesser percentage of the Medicare rates for applicable DME items or by amending its state-developed fee schedule, the state must submit a state plan amendment no later than March 31, 2018. The effective date must be no later than January 1, 2018, in accordance with the new statutory requirement.

States electing to submit an aggregate payment comparison, or an alternative approach to compliance as mentioned earlier in this letter, will inform CMS of that choice by December 31, 2017, and calculate the FFP limit for their state using expenditures for the period of January 1, 2018 through December 31, 2018. CMS is in the process of obtaining the required Office of Management and Budget (OMB) approval for these payment comparisons via the Paperwork Reduction Act (PRA) process[5]. Only after CMS obtains a valid OMB control number will States be required to submit this information. Assuming PRA approval, the first comparative analysis must be submitted to CMS by March 31, 2019. States electing to use alternative approaches will be asked to provide descriptions of the proposed methodology for review by CMS. For subsequent years, CMS will request that states notify CMS of any changes to their method of compliance by December 31st and the submitted demonstrations would be completed for the January 1 through December 31 period of the following year, and submitted by March 31.

If the state should discover that its payments for DME items subject to statute exceed the FFP limit, the overpayment must be returned to CMS. If the overpayment is not returned, CMS will

[5] November 28, 2017 (82 FR 56242)

initiate disallowance proceedings. See 42 C.F.R. § 430.42. States are encouraged to review aggregate DME expenditures each quarter to ensure that the calculation method is accurate and that state expenditures are consistent with the statute in order to limit any liability related to this new statutory provision.

We look forward to working with you and are available to answer any questions you may have or to provide additional technical assistance to you. For additional information, please direct your request to MedicaidDME@cms.hhs.gov.

Sincerely,

/s/

Brian Neale
Director

cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
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