



Limiting Federal Financial Participation for Medicaid Reimbursement to States for Durable Medical Equipment



*State Medicaid
Director Letter
and
Data Demonstration
2018*

Statutory Provision

Section 1903(i)(27) of the Social Security Act:

“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, 2018, 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.”

Background

- **September 2015** - OIG Report on Medicaid payments for DME compared to Medicare post Competitive Bidding Program suggesting Medicaid should limit payments for DME by comparing Medicare and Medicaid aggregate payments
- **December 2015** - Congress passed Sec. 503 of the Consolidated Appropriations Act of 2016 which amended Sec. 1903(i)(27) of the Social Security Act, effective **January 1, 2019**
- **December 2016** – Sec. 5002 of the 21st Century Cures Act amended Sec. 1903(i)(27) of the Social Security Act , effective **January 1, 2018**

Medicare Payment for DME

Medicare Part B pays for DME using two methods:

1. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule rates published on the CMS website (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>); or
2. A “single payment amount” 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), which are designated by the Office of Management and Budget (OMB) (<https://www.dmecompetitivebid.com/>).

DME Items Affected

Which items of DME are affected by the statute?

- Items that are covered by both Medicare *and* Medicaid; and
- Items for which Medicare has established a payment rate.

DME Items *Not* Affected

Which items of DME are *not* affected by the statute?

- Items for which Medicare has not set a payment rate
- Items that are not covered by Medicare (no paid claims) are not subject to the aggregate limit.
- Items covered by Medicaid, but not Medicare are not subject to the limit.
- Items provided and reimbursed as part of an institutional payment.

How will the limit be calculated?

Federal financial participation (FFP) is limited to:

“...amounts that would be paid by Medicare under the existing fee for service rate or, as applicable, the rate established under a competitive acquisition program within specific areas of the state for items that are covered by the Medicare program”

States must factor the **Medicare competitive bidding rates** when demonstrating aggregate Medicaid payments for DME

State Compliance Options

States can comply with the rule by either:

1. Submitting a state plan methodology which ties reimbursement for DME items to the published applicable Medicare payment rates, which would include the DMEPOS fee schedule and any competitive bidding rates within Medicare-defined geographic areas of the state (if any)
 - E.g., using 80% of the Medicare fee schedule for Medicaid
2. Submitting a UPL using one of the two UPL methodologies for their demonstration (details on the next slide)

UPL Methodology Options

Method 1: UPL Calculation using all Medicare rate areas in a state, including DMEPOS and competitive bidding areas based on where the item of DME was provided

This would require a state to run claims queries by HCPCS codes, claims modifier, and region of the state using Medicare competitive bidding area mapping, and develop an aggregate comparison between Medicaid payments for DME provided in those areas to the Medicare payment rate for the corresponding area.

Method 2: UPL Calculation using the Lowest Available Medicare Payments for DME

This would require a state to run claims queries by HCPCS codes, claims modifier regardless of where the service occurred and calculate the UPL using the lowest of the DMEPOS fee schedule rates or the competitive bidding area rates within the state.

General FAQs

1. How will CMS determine the list of HCPCS codes that are subject to the limit?

Response: CMS will request a query from the Medicare contractor on HCPCS code series A, E, and K to identify codes identified as Medicare covered DME.

2. If Medicare only establishes a rental price, but not a purchase price, are those items subject to the limit such as capped rental items?

Response: CMS considers the prices established for capped rental items as sufficient for comparison to rental prices in Medicaid, and used a formula provided by Medicare to determine the purchase price for those items.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2142CP.pdf>

3. If payments for DME exceed that which Medicare would have paid, how will CMS go about collecting FFP?

Response: CMS will use the authority in Section 1903(d) of the Social Security Act and 42 C.F.R. 433 Subpart F. The same process that is used in other circumstances when overpayments are identified.

4. Are states to use the Medicare 2017 rates for the 2018 period, or would the 2018 rates be the most appropriate?

Response: Since the limit is effective date is January 1, 2018, we advise states to use the 2018 Medicare rates, and updated for subsequent years.

General FAQs

5. A number of states set purchase and rental prices where Medicare only sets a rental price on their fee schedule. Will CMS expect states to compare Medicaid purchase prices to Medicare rental prices?

For all items other than power wheelchairs (K0813 thru K0864), the rental fees for months 1-3 are based on 10 percent of the average purchase price from the 6 month period in 1986 (as required by law), updated by the update factors and limited by the national ceiling (median of all state fees) and floor (85% of the median fee). These are the RR amounts on the fee schedule file. So, to translate them back to purchase amounts, you can just multiply the RR fee on the fee schedule file by 10.

For power wheelchairs (K0813 thru K0864), the rental fees for months 1-3 are based on 15 percent of the average purchase price, updated by the update factors and limited by the national ceiling (median of all state fees) and floor (85% of the median fee). These are the RR amounts on the fee schedule file. So, to translate them back to purchase amounts, you need to divide the RR amount on the file by 0.15 (see attached instructions). There is no purchase fee paid for capped rental items other than complex rehabilitative power wheelchairs per 1834(a)(7)(A)(iii). For these items, the carriers divide the fee on the file by 0.15 to get the purchase fee.

DME FFP Limit Calculation Tool

To assist states with their efforts, CMS has developed a tool that states can use that will be maintained and updated by CMS.

The tool uses the most recent Medicare payment rate (both DMEPOS and Competitive Bidding Single Payment Amounts) and Medicare claims data to identify all applicable items of DME subject to the statute.

DME FFP Limit Calculation Tool

To calculate the limit, CMS will need the following data from states:

1. A List of all DME used organized by HCPCS code;
2. Aggregate claims volume for each code for the prior 12 month period;
3. Payment rates for each applicable code;
4. Any Medicare claims modifiers;
5. A crosswalk of any state-developed claims modifiers to the Medicare claims modifiers; and
6. If available, the state can also categorize claims by regional area of the state using the specific Medicare competitive bidding areas for your state, non-rural, or rural designations

This information is requested under Paper Work Reduction Act Request CMS-10661, which currently published in the Federal Register for a 60-day comment period.

DME Tool Medicare Data Sources

- Medicare DMEPOS fee schedule; HCPCS series A, E, & K.
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>
- Medicare Competitive Bidding Single Payment Amounts from the Medicare Contractor site (<https://www.dmecompetitivebid.com/>).
- Medicare billed/paid claims list for HCPCS series A, E, & K from the Medicare Pricing, Data Analysis, and Coding (PDAC) contractor.

Additional Resources

- Please send questions or requests for additional information to MedicaidDME@cms.hhs.gov
- Paper Work Reduction Act Documents: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10661.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>
- Federal Register Notice for PRA: https://www.regulations.gov/document?D=CMS_FRDOC_0001-2303