**CMS’ Implementation of the DME**

**Medicaid Cap May Adversely Impact the**

**Disabled Population**

In 2015 and 2016, Congress passed provisions capping the federal portion of Medicaid reimbursement for certain durable medical equipment (DME) items. While AAHomecare had concerns with the policy before it became law, it is not advocating to repeal the requirement. The Association is concerned with CMS’ implementation of the requirement, which could seriously impact Medicaid beneficiaries’ access to the DME items and related services. AAHomecare would like to work with Congress to ensure that the implementation of the Medicaid cap does not impact patient care and is not onerous to small businesses. The following is information regarding the statutory language, implementation timeline, industry concerns, and possible solutions.

**Medicaid Cap for DME Items – Statutory Language**

**H.R. 2029 – P.L. 114-113**

**SEC. 503. LIMITING FEDERAL MEDICAID REIMBURSEMENT TO STATES FOR DURABLE MEDICAL EQUIPMENT (DME) TO MEDICARE PAYMENT RATES.**

(a) Medicaid Reimbursement. --

 (1) In general.--Section 1903(i) of the Social Security Act

 (42 U.S.C. 1396b(i)) is amended--

 (A) in paragraph (25), by striking ``or'' at the

 end;

 (B) in paragraph (26), by striking the period at the

 end and inserting ``; or''; and

 (C) by inserting after paragraph (26) the following

 new paragraph:

 ``(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.''.

 (2) Rule of construction.-- Nothing in the amendments made by paragraph

 (1) shall be construed to prohibit a State Medicaid program from providing

 medical assistance for durable medical equipment for which

 payment is denied or not available under the Medicare program

 under title XVIII of such Act.

 (b) Evaluating Application of DME Payment Limits Under Medicaid.--

The Secretary of Health and Human Services shall evaluate the impact of

applying Medicare payment rates with respect to payment for durable

medical equipment under the Medicaid program under section 1903(i)(27)

of the Social Security Act, as inserted by subsection (a)(1)(C). The

Secretary shall make available to the public the results of such

evaluation.

**H.R. 34 – P.L. 114-134**

**SEC. 5002. MEDICAID REIMBURSEMENT TO STATES FOR DURABLE MEDICAL**

**EQUIPMENT.**

 Section 1903(i)(27) of the Social Security Act (42 U.S.C.

1396b(i)(27)) is amended by striking ``January 1, 2019'' and inserting

``January 1, 2018''.

**Timeline of DME Medicaid Cap**

* December 18, 2015-Congress passes H.R. 2029 Omnibus Appropriations bill, which included a provision to cap the federal portion of DME Medicaid reimbursement starting on January 1, 2019.
* December 13, 2016-21st Century Cures signed into law, which included a provision to move the DME Medicaid cap to January 1, 2018.
* September 13, 2017-First response from CMS to A Homecare regarding Cures guidance.
* September 19, 2017-First meeting with AAHomecare regarding Cures guidance and discussion.
* November 28, 2017-Federal Register Posting for Intent to Collect Information with January 28, 2017 comment deadline.
* December 7, 2017-State Operational Technical Assistance (SOTA) call held by CMS for all states. No State Medicaid Director Letter published at this time. No guidance on specific items included in legislature. Discussed DME that is reusable with useful life of greater than 3 years are only items included in legislature. Incorrectly spoke on webinar that oxygen was not included. Contact by AAHomecare immediately following webinar to confirm this and was told that this was “misspoken” on the webinar and would be clarified in Q&A when SMDL published.
* December 12, 2017-CMS provided to AAHomecare the preliminary HCPCS list included.
* December 27, 2017-2pm-State Medicaid Director letter published. SMDL referenced appendices that were not attached. Also implemented deadline of 12/31/17 for states to inform CMS if they were going to complete the reconciliation.
* December 27, 2017-AAHomecare outreach to CMS regarding short timeframes for states to notify them of intent to complete reconciliation.
* January 4, 2018-Updated SMDL letter published removing the 12/31/17 deadline for states. Appendices still not published.
* January 25, 2017-AAHomecare call with CMS regarding publishing of HCPCS Listing and Appendices necessary for states to evaluate their options and budgetary spend. AAHomecare was informed that they were still working on publishing these items. They are re-evaluating the HCPCS with 2017 claims data from PDAC to ensure they have included all codes in preliminary list.

**Additional Info to Consider**

* It has been requested that CMS be completely transparent with the state and DME providers in findings on any reconciliation data, including breakdown by procedure code for aggregate spend. This information will be important for the state Medicaid programs and industry stakeholders to partner together to ensure access to care for Medicaid beneficiaries.
* Conversations with multiple state Medicaid programs have shown that the eight hours estimated by CMS for data collection by the states has been grossly underestimated. One state Medicaid program stated “We have already spent more than eight hours at this point and have not begun to analyze the data. This will cost states millions of dollars in programming efforts and will take more than a year to complete.”
* There is concern around the ongoing accuracy of the CMS Data Tool that was developed with changes in pricing and regulatory changes. AAHomecare would like to know the process for any retro fee schedule adjustments that may occur due to current legislation and Interim Final Rule that could retroactively change Medicare payment rates. What is the process for how this reconciliation would occur if these changes take place?
* The guidance issued in the State Medicaid Director Letter gives direction to states to change all items covered by Medicare and Medicaid to follow Medicare pricing. There are only 255 HCPCS covered under the definition of DME impacted by this directive. The guidance given by CMS is impacting all 1149 HCPCS covered by both programs including medical supplies, prosthetics, orthotics, and accessories.
* Most Medicaid MCO plans follow Medicaid fee schedules or a discount off of Medicaid fee schedules. This directive is impacting not only the 20.5 million beneficiaries covered by primary Medicaid Fee For Service but also indirectly impacting the 55 million beneficiaries covered by Medicaid MCO plans. Implementation of this legislation will impact access to care for 75 million beneficiaries across the country. This includes 36 million pediatric beneficiaries.
* To date, CMS has not published the HCPCS codes impacted by this legislation or the appendices referenced in the 12/27/17 (and updated 1/4/18) State Medicaid Director Letter. States cannot make accurate decisions impacting their programs without this important information. CMS had over one year to issue guidance to the states and did not issue any guidance until a webinar held on 12/7/17. During this webinar it was indicated that further official guidance would be issued to the state Medicaid programs through a State Medicaid Director Letter. This letter was not published until 12/27/17 giving the states only four days prior to having to make a decision

**CMS Overstepping:**

* Issuing guidance in appendices for states to update their state plan amendments for all rates to follow Medicare pricing. This is impacting items such as medical supplies, O&P, and DME Accessories and Supplies that are not included in the legislation.
* State plan amendments must be submitted by 3/31/18 but retroactively change rates for state Medicaid programs to 1/1/18. This will create a burden to states and providers in having to adjust retroactive claims pricing.
* States are still very confused about what this change means due to lack of HCPCS listing being provided and no appendices attached to guidance. To date, these are still not published.
* States have a 30-60 day required timeframe for comments for rate changes. Due to late guidance issued by CMS, states were not able to obtain these comments prior to the 1/1/18 effective date. This has caused some states to react by publishing notice to change their rates to Medicare rates without any information. Other states are having to complete comment periods now and will have to retroactively change fee schedules.
* States were not given any time or appropriate information to analyze the potential access to care that could occur with any rate changes.
* The amount of time it will take for reconciliation was underestimated by CMS according to many states.
* States are responding in one of four ways:
	+ Changing all codes to Medicare rates
	+ Changing all codes but O&P to Medicare rates (impacting supplies, enteral feeding, and DME accessories-not included in legislature)
	+ Changing just codes on HCPCS list we have provided to them.
	+ Opting to complete reconciliation to ensure they have appropriate time to evaluate access to care. This may create budget shortfalls for the Medicaid programs in 2019 when reconciliation is completed.

**Ask for Congress**

1. Limit the number of codes subject to the Medicaid cap – Competitive Bidding items only
2. Clarify that CMS should not encourage or push states to lower their portion of Medicaid reimbursement, which is not included in the statute
3. Insist on the completion of the patient impact survey before implementing the provision to limit the federal portion of DME Medicaid reimbursement.