Brown & Fortunato, P.C.
A LAW FIRM

Jeffrey S. Baird
806-345-6320
jbaird@bf-law.com

Board Certified, Health Law
Texas Board of Legal Specialization

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Mr. Thomas Ryan
American Association of Homecare
241 18th Street, South-Suite 500
Arlington, VA 22202 ***Via Email TomR@aahomecare.org***

Re: Federal Match for DME Expenditures and Medicaid Payment Rates

Dear Mr. Ryan:

President Obama recently signed into law the 21st Century Cures Act.[1] This Act moved up the date on which the federal government will begin determining the portion of a state Medicaid Program's expenditures on DME that it will cover based on how much Medicare would have paid for the same items of DME under the Competitive Bidding Program. Because state Medicaid Programs are or will be reacting to this change, it is important to understand whether each state Medicaid Program has a corresponding requirement to align its DME fee schedule rates with the rates established under Medicare's Competitive Bidding Program. Based on our research, state Medicaid Programs are not required to adopt or otherwise align payment rates for DME with those established under Competitive Bidding.

Limitation on Federal Coverage of State Medicaid Expenditures

Medicaid is funded by contributions from the federal government and from the individual states. Congress has statutorily laid out the amount the federal government will pay to each state for the various items and services covered by the state's Medicaid Program. This figure is expressed as a percentage of the amount expended by a state for a given category of items or services, and the statute includes seven different categories of items and services.[2] Six of these categories cover expenditures made by a state for specific things, such as items and services falling under the definition of "medical assistance" or preadmission screening activities. The seventh

[1] Public Law No: 114-255.
[2] 42 U.S.C. § 1396b(a)(1)-(7).

category, however, is a catchall for the remainder of the amounts expended that do not fall under the other six categories, and it states that the federal government will pay 50% of those amounts.

In addition to the expenditure percentage calculation, the amount the federal government will pay for DME is directly subject to another limitation. The same statutory section that contains the seven categories and matching percentages has language stating that the federal government will not make payments for amounts expended by a state on DME that are in excess of the aggregate amount that Medicare Part B would have paid for the DME under the Competitive Bidding Program.[3] In other words, the federal government's funding for Medicaid-covered DME is limited to a percentage of the Competitive Bidding Program rates for the same items.

State Medicaid Rate Guidelines

While these limitations on how much of a state's DME expenditures the federal government will cover are critical for a state Medicare Program to understand, it is also important to understand that these limitations do not dictate what a state Medicaid Program is permitted to set as its fee schedule rates. The limitations on how much a state Medicaid Program may ultimately pay for a covered item or service are found elsewhere. The Social Security Act contains a broad directive that a state Medicaid Program must "provide such methods and procedures relating to the . . . payment for . . . care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan . . . ."[4] CMS's regulations confirm that "[w]ithin broad Federal rules, each State decides . . . payment levels for services . . . ."[5] So it is clear that states have discretion in setting their Medicaid payment amounts, despite the method or percentage used by the federal government to determine what percentage of a state's expenditures it will cover.

Notwithstanding the latitude available to states in determining their Medicaid fee schedule rates, the states are required to maintain documentation related to their payment rates, including a comparison of the Medicaid Program's payments rates to other public and private health insurer payment rates.[6] In addition, CMS imposes firm "upper payment limits" on some provider types. For instance, a state Medicaid Program may not pay:

- a provider more for inpatient hospital services than the provider's customary charges to the general public[7];

[3] *Id.* at § 1396b(i)(27).
[4] *Id.* at § 1396a(a)(30)(A).
[5] 42 C.F.R. § 430.0; *see also Medicaid Financing & Reimbursement*, *available at* https://www.medicaid.gov/medicaid/financing-and-reimbursement/.
[6] 42 C.F.R. § 447.203(a), (b)(3).
[7] *Id.* at § 447.271(a).

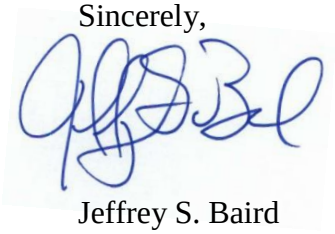
- a hospital, nursing facility, or long term care facility more than would be paid under Medicare[8];
- a provider of outpatient hospital or clinic services more than would be paid under Medicare[9]; and
- a provider of other inpatient and outpatient facility services more than the prevailing charges in the locality for comparable services under comparable circumstances.[10]

However, none of the upper payment limits imposed by the CMS regulations apply to DME.[11] Accordingly, state Medicaid Programs' payment rates for DME are not subject to an express upper payment limit and must only comply with the broad requirement to ensure efficiency, economy, and quality of care.

Conclusion

Congress has determined that the federal match for Medicaid expenditures on DME will be based on what Medicare's expenditures for the same DME would have been under the Competitive Bidding Program. And Congress recently hastened the institution of this limitation on the federal match. But a state Medicaid Program is not obligated by federal law or rule to limit its DME payment rates to those established under the Competitive Bidding Program. States are free to set Medicaid payment rates for DME at levels that assure efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available.

Sincerely,



Jeffrey S. Baird

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[8] *Id.* at § 447.272(b)(1).
[9] *Id.* at § 447.321(b)(1).
[10] *Id.* at § 447.325.
[11] See also Guidance on Annual Upper Payment Limit Demonstration, available at https://www.medicaid.gov/medicaid/financing-and-reimbursement/accountability-guidance/index.html.