



Implementation of the 21st Century Cures Legislation Limiting Federal Financial Participation Match for State Medicaid Expenditures

Background

The Omnibus bill of 2015 (H.R. 2029-P.L. 114-113) included a provision to limit the federal portion of funding for state Medicaid programs to the Medicare rates for Durable Medical Equipment, also known as Home Medical Equipment (HME). On December 13, 2016, President Obama signed into law the 21st Century CURES legislation (PL 114-255) that moved the effective date of this provision to January 1, 2018. This controversial provision will create hardships for the Medicaid programs trying to serve their Medicaid population who require vital HME to maintain their independence at home and an active lifestyle in the community. States who adopt Medicare rates based on a flawed competitive bidding program will put beneficiaries at risk and will be unable to provide 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

CMS Discussion and Preliminary Guidance

- CMS will issue a letter to State Medicaid Directors soon.
- The implementation is based on the September 2015 OIG report titled “State Medicaid Agencies Can Significantly Reduce Medicaid Costs for DME and Supplies”. This study was performed in 4 states comparing one year’s worth of claims paid by the state Medicaid programs in California, Minnesota, and Ohio and two years of claims paid in New York for competitive bidding codes. The report is available at <https://oig.hhs.gov/oas/reports/region5/51500025.pdf>.
- Effective with Dates of Service 1/1/2018, the legislation mandates that the calculation for the Federal Financial Participation match (FFP) for Medicaid service cannot be based on rates higher than the Medicare allowable.
- This impacts all E and K HCPCS codes covered by Medicare and Medicaid. Further analysis is being completed by CMS on the specific list of HCPCS codes that will be provided in the guidance letter
- State Medicaid programs **DO NOT** have to set their rates at Medicare allowable. States have the flexibility to set their own rates to ensure access to care.
- Calculations will be based on aggregate expenditures for all Medicare/Medicaid covered HCPCS codes. Items currently priced by Medicaid programs below Medicare allowable will be included in the aggregate reconciliation and can make up for the items priced above Medicare allowable.

- The Medicare allowable will be calculated in the aggregate and more guidance is forthcoming on which Medicare rate should be used. (i.e. CBA SPA Rate, Rural Rate, Regional Rate). It has been discussed by CMS that states will have to calculate this based on area patient lives.
- Due to Medicaid MCO contracts being paid as capitated agreements from the state, they are exempt from this legislation. However, the Medicaid MCO plans that follow Medicaid fee schedules will be impacted based on rate setting decisions made by the state.
- State Medicaid Programs that have questions regarding this legislation should contact their CMS Regional Office. Contact information for these offices can be found at <https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html>.

Preliminary Proposed Process by CMS

- States will continue to obtain their quarterly match with the current system.
- Annual reconciliation will be required from the states to compare their claims paid to the Medicare allowable and new FFP amount established.
- States must reimburse the federal government the difference in the initial FFP match and the newly calculated FFP match based on Medicare allowables.

Example

Medicaid Paid Claims-\$2,000,000

Medicaid Initial Match (assume 50%)-\$1,000,000

Annual reconciliation for Same Claims

Medicare Allowed on Paid Claims-\$1,500,000

Actual Match after implementing FFP limitation-\$750,000

State payment back to Feds-\$250,000 (difference between initial FFP amount and new FFP amount based on limitation)

**This material is based on preliminary discussions with CMS and is subject to change before official guidance is offered by CMS. AAHomecare will continue to monitor