Appendix A
Medicare Definition of DME

Medicare defines DME used in a patient's home at section 1861(n) of the Social Security Act (the Act) and DME is a Part B benefit[1]. In accordance with section 1861(n) of the Act, 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. The patient's home includes an institution used as his or her home other than a hospital or skilled nursing facility. Besides being subject to this provision, in order to be covered under the Medicare program, the item of DME must satisfy the requirements of section 1862(a)(1)(A) of the Act, which in general prohibits payment for any item or service that is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and section 1862(a)(6) of the Act, which (except for certain specified exceptions) precludes payment for personal comfort items. Medical nutritional therapy supplies and equipment provided under a separate authority is not included in Medicare's definition of DME.

Medicare regulation at 42 C.F.R. § 414.202 further defines DME as equipment furnished by a supplier or a home health agency that meets the following conditions: (1) Can withstand repeated use; (2) effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years; (3) is primarily and customarily used to serve a medical purpose; (4) generally is not useful to an individual in the absence of an illness or injury; and (5) is appropriate for use in the home. The number of items of DME in the Medicare program is not static and may increase with medical innovation.

Section 1847(a) of the Act requires that Medicare establish a competitive bid process for contract award purposes for furnishing certain items and services[2]. In 2017, there were 130 competitive bidding areas (CBAs) in 99 metropolitan service areas (MSAs). MSAs are designated by the Office of Management and Budget (OMB) and include major cities and the suburban areas surrounding them, while the CBAs are the areas in which the Medicare competitive bidding contracts and single payment amounts are effective. Currently, there are seven states that do not have any CBAs, and no CBAs have been established in any of the territories. Forty-four states have at least one CBA and states range between one and twelve CBAs.

For purposes of the FFP limit for Medicaid DME services established under section 1903(i)(27) of the Act, those 44 states are required by the statute to use the Competitive Bidding Program (CBP) single payment amounts for certain items of DME furnished within a CBA as part of the

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[1] 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."

[2] 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.

calculation of the FFP limit. DME provided outside of a defined CBA is subject to the DMEPOS fee schedule amount, using the zip code data available on the Medicare DME Competitive Bidding Program website.[3] States that do not have any of the designated CBAs under the CBP use the DMEPOS fee schedule amounts in applying the FFP limit. Not all items are subject to competitive bidding; items and services included under the DMEPOS CBP are outlined under 1847(a)(2) of the Act.

[3] https://www.dmecompetitivebid.com/

Appendix B
Compliance through State Plan Reimbursement Methodologies

As discussed in State Medicaid Director Letter (SMDL), one method for states to comply with section 1903(i)(27) of the Act is to submit a state plan amendment which would explicitly set state payment rates for DME at or below the existing Medicare rates using either the lowest available Medicare rate, or the rate applicable to certain areas of the state under Medicare competitive bidding, including rural and non-rural areas. The language below is suggested State plan language to communicate the state's approach for Medicaid DME reimbursement. As always, states have the flexibility to suggest alternative state plan methodologies to demonstrate compliance with the statute, subject to CMS approval.

For a state that has no Medicare Competitive Bidding Areas (CBAs), the state plan methodology could be written as follows:

Reimbursement for DME provided in non-rural areas is set at the lower of the following:

1. *The Medicare DMEPOS fee schedule rate for [state] geographic, non-rural areas, set as of Jan. 1 each year, and updated on a quarterly basis (April 1, July 1, October 1) as needed;*
2. *The provider's charge; or*
3. *Actual acquisition cost, plus x%.*

For items of DME provided in rural areas, the rate is set at the lower of the following:

1. *The Medicare DMEPOS fee schedule rate for [state] geographic, rural areas, set as of Jan. 1 each year, and updated on a quarterly basis (April 1, July 1, October 1) as needed;*
2. *The provider's charge; or*
3. *Actual acquisition cost, plus x%.*

For a state that has one or more Medicare CBAs, the state plan methodology could be written as follows:

For items of DME provided in Medicare Competitive Bidding Areas (CBAs) where rates for specific items have been competitively bid under the Medicare program, the rate is set at the lower of the following:

1. *The Medicare single payment amount specific to the geographic area where the item is being provided, that are in effect as of Jan. 1 each year, and updated on a quarterly basis (April 1, July 1, October 1) as needed;*
2. *The provider's charge; or*
3. *Actual acquisition cost, plus x%.*
4. *The non-rural and rural DMEPOS fee schedule rate*

If there is no competitively bid payment rate for an item of DME in a CBA, then one of two methodologies will apply:

Reimbursement for DME provided in non-rural areas is set at the lower of the following:

1. *The Medicare DMEPOS fee schedule rate for [state] geographic, non-rural areas, that are in effect as of Jan. 1 each year;*
2. *The provider's charge; or*
3. *Actual acquisition cost, plus x%.*

For items of DME provided in rural areas, the rate is set at the lower of the following:

1. *The Medicare DMEPOS fee schedule rate for [state] geographic, rural areas, set as of Jan. 1 each year;*
2. *The provider's charge; or*
3. *Actual acquisition cost, plus x%.*

Appendix C
Methods to Identify Medicare Covered DME

In calculating the FFP limit, states are required to choose one of two methods to identify covered Medicare DME:

1. **Full scope of DME listed on the DMEPOS fee schedule** – States may use the full scope of DME available on the DMEPOS fee schedule for the HCPCS code sets identified in the SMDL. Medicare sets payment rates for most HCPCS codes for DME, prosthetics, orthotics, and supplies but the presence of a payment rate does not imply actual Medicare coverage. Using this method, states would likely limit payments for more items than the statute requires since items that have an established rate are not all covered by Medicare. The Medicare fee schedule can be found at the following website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html

2. **A list of Medicare-covered DME from the Medicare Pricing, Data Analysis and Coding (PDAC) Contractor** – Medicare's regional DME MACs are responsible for making Local Coverage Determinations (LCDs) and make coverage determinations based on Medicare's National Coverage Determinations (NCDs). DME is specifically discussed in section 280.1 of the Medicare National Coverage Determinations Manual. One of the PDAC's tasks is to perform data analysis on DMEPOS claims. States, through CMS, may request from the PDAC a list of billed and paid DME (for only the HCPCS codes identified above) for the previous year, and crosswalk those codes to the payment amounts on the DMEPOS fee schedule. This will serve as the list of applicable Medicare covered DME for the state's comparison. If interested in this source of data, states are asked to work through the CMCS central and regional offices for assistance.

Once the state selects a demonstration method, the state would then calculate the aggregate Medicaid DME FFP limit using the Medicaid utilization applied to the Medicare payment rates for each item of DME subject to the limit. States must use the single payment amounts from the CBA, where applicable, or use the lowest available Medicare rate as a comparison. If the aggregate Medicaid payments are less than or equal to the aggregate Medicare equivalent payments, then the state will be considered compliant with the statute, as explained in more detail in Appendix D and E.

Some additional considerations, requirements, and suggestions:

- If states choose the DMEPOS fee schedule file for their list of codes, states may use the list published by January 1 of each year for consistent application of the FFP limit.

- For states that use options 2, the list of billed and paid claims should use the previous 12 months of claims data from Medicare so that there may a full complement of billed and paid DME from Medicare.

- States are required to use actual Medicaid claims utilization data and Medicaid payment rates, by applicable Healthcare Common Procedure Coding System (HCPCS) codes, to establish the aggregate Medicaid DME expenditures.

- States should review Medicaid payments for DME on a quarterly basis to review on-going, real-time compliance with section 1903(i)(27) of the Act, then submit calculations of the aggregate limit to CMS on an annual basis prior to the start of the state's fiscal year.

Appendix D
Calculation of the FFP Limit using the Lowest of the Medicare DMEPOS or Competitive Bidding Rate

To assist states in demonstrating that aggregate payments do not exceed the aggregate limit defined in statute, CMS is providing the following example for states. The following demonstrates how a state could use the Medicaid payment rates by Healthcare Common Procedure Code System (HCPCS) code, a code modifier, and claims volume and compare it to the Medicare payment rate for the same code. This appendix uses the lowest Medicare payment amount in the event that a state is unable to differentiate between claims that occurred in a competitive bidding area (CBA) and those that occurred in other areas of the state. Using the lowest rate in the absence of regionally differentiated claims volume would allow states to make a conservative demonstration in the current period.

1. Identify the universe of codes and payment amounts that represent Medicaid DME, and the utilization for those codes (this can come from the MMIS system).

HCPCS Code	Mod 1	Medicaid Rate	Medicaid Volume	Medicaid Expenditures
E0111		$ 43.01	9	$ 387.09
E0111	RB	$ 25.81	9	$ 232.29
E0111	RR	$ 4.30	9	$ 38.70
E0130		$ 56.72	9	$ 510.48
E0130	RB	$ 34.03	9	$ 306.27
E0130	RR	$ 5.67	9	$ 51.03
E0140		$ 291.27	9	$ 2,621.43
E0140	RB	$ 174.76	9	$ 1,572.84
E0140	RR	$ 29.13	9	$ 262.17

2. Identify the Medicare payment amounts for those codes. This assumes the "lower of" methodology described in the letter.

Medicare HCPCS	Medicare DME Rate (Non-Rural)	Medicare DME Rate (Rural)	CBA #1	CBA #2	CBA #3	Lowest Medicare CBA Amount	Lower of DMEPOS & CBA Rates
E0111NU	$ 58.87	$ -	$ -	$ -	$ -	$ -	58.87
E0111UE	$ 45.44	$ -	$ -	$ -	$ -	$ -	45.44
E0111RR	$ 9.31	$ -	$ -	$ -	$ -	$ -	9.31
E0130NU	$ 45.05	$ 52.13	$ 44.01	$ 44.70	$ 45.24	$ 44.01	44.01
E0130UE	$ 33.79	$ 39.10	$ 33.01	$ 33.53	$ 33.93	$ 33.01	33.01
E0130RR	$ 4.51	$ 5.21	$ 4.40	$ 4.47	$ 4.52	$ 4.40	4.40
E0140NU	$ -	$ -	$ -	$ -	$ -	$ -	-
E0140UE	$ -	$ -	$ -	$ -	$ -	$ -	-
E0140RR	$ 26.61	$ 29.52	$ 25.15	$ 26.19	$ 26.95	$ 25.15	25.15

3. Identify the Medicaid expenditures which have a payment amount on the Medicare fee schedule, removing those with no payment rate, and calculate the difference. The aggregate difference, if Medicaid is less than Medicare, demonstrates that the state is in compliance with the statute.

Medicare HCPCS	Medicaid Expenditures for Medicare-Covered	Medicare UPL Medicaid Vol x Medicare Rate	Difference
E0111NU	$ 387.09	$ 529.83	$ 142.74
E0111UE	$ 232.29	$ 408.96	$ 176.67
E0111RR	$ 38.70	$ 83.79	$ 45.09
E0130NU	$ 510.48	$ 396.09	$ (114.39)
E0130UE	$ 306.27	$ 297.09	$ (9.18)
E0130RR	$ 51.03	$ 39.60	$ (11.43)
E0140NU	$ -	$ -	$ -
E0140UE	$ -	$ -	$ -
E0140RR	$ 262.17	$ 226.35	$ (35.82)

Appendix E
Calculation of the FFP Limit –
Using Claims provided in Competitive Bidding Areas and Non-Competitive Bidding Areas in the same manner as Medicare

To assist states in demonstrating that aggregate payments do not exceed the aggregate limit defined in statute, CMS is providing the following example for states. The following demonstrates how a state could use the Medicaid payment rates by Healthcare Common Procedure Code System (HCPCS) code, a code modifier, and claims volume and compare it to the Medicare payment rate for the same code. This appendix uses the Medicare payment amount by Competitive Bidding Area (CBA) as well as the rural and non-rural areas of the state where a state is able to differentiate between claims that occurred in a competitive bidding area (CBA) and those that occurred in other areas of the state, as directed by the statute.

1. Identify the universe of codes and payment amounts that represent Medicaid DME, and the utilization for those codes along with assigning the area where each claim occurred to one of the Medicare assignment areas. "NR" is non-rural; "R" is rural; and each CBA can be assigned a number. In this case, 1 – 2 – 3.

HCPCS Code	Regional Area	Mod 1	Mod 2	Medicaid Rate	Medicaid Volume	Medicaid Expenditures
E0111	NR			$ 43.01	3	$ 129.03
E0111	R			$ 43.01	1	$ 43.01
E0111	1			$ 43.01	2	$ 86.02
E0111	2			$ 43.01	1	$ 43.01
E0111	3			$ 43.01	2	$ 86.02
E0130	NR	RR		$ 5.67	3	$ 17.01
E0130	R	RR		$ 5.67	1	$ 5.67
E0130	1	RR		$ 5.67	2	$ 11.34
E0130	2	RR		$ 5.67	1	$ 5.67
E0130	3	RR		$ 5.67	2	$ 11.34
E0140	NR			$ 291.27	3	$ 873.81
E0140	R			$ 291.27	1	$ 291.27
E0140	1			$ 291.27	2	$ 582.54
E0140	2			$ 291.27	1	$ 291.27
E0140	3			$ 291.27	2	$ 582.54

2. Identify the Medicare payment amounts for those codes. Use each relevant code as applicable. If DMEPOS only has a rate for the NR area, this code will apply to the rural area, too. If there is a rate for the NR, but not the CBAs, then the NR rate is applicable to the CBAs.

Medicare HCPCS	Medicare DME Rate (Non-Rural)	Medicare DME Rate (Rural)	CBA #1	CBA #2	CBA #3	Medicare Rate
E0111NU	$ 58.87					$ 58.87
E0111NU		$ 58.87				$ 58.87
E0111NU			$ -			$ 58.87
E0111NU				$ -		$ 58.87
E0111NU					$ -	$ 58.87
E0130RR	$ 4.51					$ 4.51
E0130RR		$ 5.21				$ 5.21
E0130RR			$ 4.40			$ 4.40
E0130RR				$ 4.47		$ 4.47
E0130RR					$ 4.52	$ 4.52
E0140NU	$ -					$ -
E0140NU		$ -				$ -
E0140NU			$ -			$ -
E0140NU				$ -		$ -
E0140NU					$ -	$ -

3. Identify the Medicaid expenditures which have a payment amount on the Medicare fee schedule, removing those with no payment rate, and calculate the difference. The aggregate difference, if Medicaid is less than Medicare, demonstrates that the state is in compliance with the statute.

Medicaid Expenditures for Medicare-Covered	Medicare UPL (Medicaid Vol x Medicare Rate)	Difference
$ 129.03	$ 176.61	$ 47.58
$ 43.01	$ 58.87	$ 15.86
$ 86.02	$ 117.74	$ 31.72
$ 43.01	$ 58.87	$ 15.86
$ 86.02	$ 117.74	$ 31.72
$ 17.01	$ 13.53	$ (3.48)
$ 5.67	$ 5.21	$ (0.46)
$ 11.34	$ 8.80	$ (2.54)
$ 5.67	$ 4.47	$ (1.20)
$ 11.34	$ 9.04	$ (2.30)
$ 873.81	$ -	$ -
$ 291.27	$ -	$ -
$ 582.54	$ -	$ -
$ 291.27	$ -	$ -
$ 582.54	$ -	$ -
	TOTAL	**$ 132.76**

Appendix F
CMS Medicaid DME Limit Calculation Tool

CMS has developed a calculation tool which can be used to determine that aggregate limit using the Medicare base data referenced in the prior appendices for each state data submission.

There will be two types of demonstrations available based on the state's available data:

1. The calculation of the limit using the lowest Medicare rate.

2. The calculation of the limit based upon where the service is delivered. This could include Medicare Non-Rural (NR) and Rural (R) areas, or one of the competitive bidding areas (CBAs). For states with no CBAs, the stratification of payment could be done for services provided in the NR or the R areas.

CMS is willing to calculate the limit on behalf of the states. This would involve states providing base claims data, including HCPCS codes, volume, claims modifiers, and Medicaid payment rates. States with a large number of competitive bidding areas may benefit from stratifying their claims data by area of the state because of the variation among the numerous Medicare payment rates for certain items of DME.

CMS will update this tool with Medicare data each year, but the state data submission would not change.