

# Durable Medical Equipment Fee-for-Service Payment Policy

Durable medical equipment (DME) includes a wide range of medical equipment that is appropriate for use in the home, such as hospital beds, wheelchairs, and oxygen, as well as medical supplies that are typically not reused, such as incontinence supplies and diabetic test strips.<sup>1</sup>

The Social Security Act (the Act) does not define DME for the purposes of Medicaid; however, medical supplies, equipment, and appliances are a mandatory home health care benefit authorized by Section 1905(a)(7) of the Act. Section 1905(a)(11) of the Act also authorizes coverage and payment for certain supplies and equipment used during physical, occupational, and speech-language therapy.

Providers must comply with other state and federal requirements in order to receive payment for services, including CFR 440–456; state statutes and regulations; and billing instructions in state provider manuals.<sup>2</sup> However, states have flexibility to determine payment and coverage policies for DME. MACPAC has documented state-specific methodologies, including how states set their payment rates and covered equipment and supplies in *States' Medicaid Fee-for-Service Durable Medical Equipment Payment Policies* (MACPAC 2019a).

In fiscal year (FY) 2017, total Medicaid spending on DME was about \$7.87 billion, accounting for 14.5 percent of DME spending across all payers (MACPAC 2019b).<sup>3</sup>

## Policies for Covered Equipment and Supplies

States cover a variety of DME and may define specific coverage policies for different classes of DME. The following are some of the most common categories of covered equipment and supplies.

- **Incontinence supplies.** Forty-six states cover incontinence supplies, generally defined as absorbent products for adult incontinence such as diapers, wipes, and liners. States often set limits on allowable amounts of supplies within a given timeframe. For example, Vermont covers the following disposable incontinence products: briefs, pull-ups or pull-ons, under pads, underwear liners, guards and shields. The state will cover a maximum of 300 of any combination of these supplies per month for beneficiaries over age three.
- **Diabetic supplies.** Forty states cover diabetic supplies, which include items necessary to monitor glucose and insulin, as DME. Five states cover diabetic supplies under their pharmacy benefit.
- **Home dialysis supplies.** Seventeen states cover home dialysis supplies as DME. Home dialysis supplies include products and equipment for renal dialysis outside of a hospital, nursing facility, or



dialysis facility. Three states pay for these supplies under their Medicaid end-stage renal disease benefit.

- **Wheelchairs and accessories.** Forty-eight states cover wheelchairs and accessories including manual and power wheelchairs, power adaptive strollers, seat adjustments, and specialized adaptations. States often specify that items such as lifts and ramps are not covered accessories.
- **Prosthetics and orthotics.** Forty-six states cover prosthetics and orthotics, which may include artificial body parts or external braces to support the body.

## Payment Policies

State Medicaid programs generally pay the lesser of the charges or the maximum price allowed for DME, as indicated on a fee schedule. States use a variety of methods to develop their maximum allowable price for covered equipment and supplies, often using one or a combination of the methods described below.

- **Medicare rate or percentage of the Medicare rate.** Thirty-two states use the Medicare rate or a percentage of the Medicare rate in their base rate calculations. While Medicare uses a competitive bidding process to determine rates, states may set their rates as a fixed percentage of Medicare fee schedule.
- **Costs or charges.** Some states pay for DME based on a percentage of the provider's reported costs or charges. States typically require the charge to Medicaid participants to be the usual and customary rate charged to those with other forms of insurance. Twenty-seven states use costs or charges to set the maximum allowable price for covered equipment and supplies.
- **Percentage of manufacturer's suggested retail price.** Fourteen states pay a percentage of the manufacturer's suggested retail price (MSRP). Idaho, for example, pays providers either 75 percent of the MSRP or 110 percent of the invoiced cost.
- **Competitive bidding process.** Under a competitive bidding process, suppliers operating in specified areas submit bids for selected products. Only two states, Florida and Tennessee, use this method for all DME. Other states use competitive bidding as the payment methodology for certain DME items. For example, Indiana, Maine, Michigan, New Hampshire, and Wisconsin use competitive bidding to set payments for incontinence supplies.
- **State-determined process.** Five states have unique payment methods. For example, Missouri determines the maximum allowable fee using recommendations from a medical consultant or Medicare charge information. Eight states use either a percentage of the Medicare rate or a state-specific method to determine allowable payment rates.

## Utilization Management Policies

In addition to setting prices for individual DME items, state Medicaid programs may establish utilization management policies including prior authorization obligations, rental and repair requirements, and utilizing preferred items and supplies lists.



- **Prior authorization.** Many states require prior authorization for specialized equipment and items that cost more than a certain amount, are furnished by an out-of-state provider, or are not listed on the fee schedule. New York and Louisiana require prior authorization for all equipment and supplies.
- **Rentals and repairs.** All states pay for the rental or repair of certain items. Items that cost more than a certain limit or those that may be needed for only a short period of time are typically rented to beneficiaries. Generally, states require manufacturers to pay for repairs of rental items under warranty. States typically will only pay for repairs of purchased items when it is less costly than paying for a replacement. Additionally, repair items often need specific prior authorization.
- **Preferred items and supplies.** Some states limit payment for DME to items provided by preferred manufacturers that have agreed to pay rebates to the state. Under a rebate program, states pay providers the normal fee schedule amount for selected products and then receive a partial refund from the manufacturer. Eight states have rebate policies for at least one category of DME. For example, Indiana, New York, and North Carolina have rebate programs for diabetic supplies. The state receives rebates from preferred diabetic supply providers and requires prior authorization for diabetic supplies from non-preferred brands.

## Policy Issues

Concerns about the level and rate of growth in state and federal Medicaid expenditures for DME have prompted some policymakers to consider various strategies to reduce spending. In 2016, for example, the federal Medicaid matching rate for certain DME products paid under Medicaid fee-for-service was limited to Medicare rates (§ 1903(i)(27) of the Act, CMS 2018). The Congressional Budget Office estimated this change would reduce direct Medicaid spending by about \$2.5 billion from 2016 to 2025 (Committee on Energy and Commerce 2015).

Competitive bidding and rebate programs are frequently considered to be approaches with potential to achieve savings in Medicaid DME.

## Competitive bidding

Policymakers and others have suggested that implementing a competitive bidding program for Medicaid DME will result in millions of dollars in savings.<sup>4</sup> For example, payment for some of the most costly DME products in the Medicare program fell by an average of 50 percent when compared with rates in the year before implementing competitive bidding (MedPAC 2018).<sup>5</sup> Additionally, the Office of the Inspector General (OIG) has produced multiple reports estimating the millions of dollars that states have, or could have, saved by implementing competitive bidding in their Medicaid DME programs (OIG 2015; OIG 2014a, b, c, d; OIG 2013a, b, c, d; OIG 2012a, b). For example, as of 2012, five states operating a limited competitive bidding process reported savings of up to 50 percent for incontinence supplies (OIG 2014b).

Some stakeholders oppose use of competitive bidding in Medicaid. Common critiques include a substantially increased administrative burden, the potential for loss of business among smaller suppliers, reduced access for beneficiaries, and increased future health costs if beneficiaries do not obtain DME in a timely manner. In response to a 2013 OIG audit and recommendation, for example, New Jersey noted that



using competitive bidding for the purchase of blood-glucose test strips would likely result in a mail-order company winning the contract, which would potentially decrease access to those items for beneficiaries without confirmed or stable mailing addresses (OIG 2013d).

## Manufacturer rebate programs

States have achieved substantial savings by using manufacturer rebates. In a 2014 report, the OIG reviewed cost savings to state agencies that received manufacturer rebates for diabetes test strips. The Indiana Medicaid program saved roughly \$1.2 million in a six-month period, and New York saved about \$16.7 million in one year. The report also estimated that the Ohio Medicaid program could have saved about \$8 million in a one-year period if rebates or competitive bidding had been utilized (OIG 2014a).

Rebates are used relatively infrequently in DME payment arrangements, especially in comparison to the utilization of rebates in paying for prescription drugs. Prescription drugs, however, account for a much larger portion of Medicaid spending than DME (MACPAC 2019b). There may also be a greater pressure for states to cover specific drugs due to direct-to-consumer marketing and perceived differences in drug quality among different manufacturers, thus encouraging the use of rebates to recover some of those funds. States may also be setting DME payment rates at a level that encourages suppliers to negotiate additional discounts from manufacturers or provide lower cost products.

States may also decide not to utilize rebate programs because of additional administrative burden as well as the potential for decreased beneficiary access to products. The OIG did not calculate the administrative costs of implementing rebate or competitive bidding programs or conduct analyses of possible effects on beneficiary access for any of the states it audited.

## Endnotes

<sup>1</sup> Federal Medicaid law does not specifically define durable medical equipment (DME), but Medicaid statute (§ 1902(a)(65) of the Social Security Act (the Act)) does reference Medicare's definition of DME, medical supplies, equipment and appliances (§ 1861(n) of the Act).

<sup>2</sup> More information on [Medicaid's fee-for-service payment process](#) can be found on the MACPAC website (MACPAC 2018).

<sup>3</sup> Figures for DME spending are for fee-for-service and managed care and include retail sales of items such as contact lenses, eyeglasses, and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals.

<sup>4</sup> Section 1915(a)(1)(B) of the Social Security Act and requirements established in 42 CFR § 431.51(d) and 42 CFR § 431.54(d) specify that a state Medicaid agency may establish special procedures for the purchase of medical devices through a competitive bidding process or other process if the state assures and the Centers for Medicare & Medicaid Services (CMS) finds that adequate services or devices are available to beneficiaries under the special procedures.

<sup>5</sup> Competitive bidding for DME in Medicare was established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), and phased in nationwide beginning in 2008.



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