interChange Provider Important Message

Connecticut Department of Social Services

TO: Medical Equipment, Devices and Supplies (MEDS) Providers and Stakeholders

RE: Revisions to Previously Announced Reimbursement Changes to Durable Medical Equipment (DME) and Other MEDS Items

DATE: March 23, 2018

Summary

The Department of Social Services (DSS) is revising the previously announced changes to MEDS reimbursement effective **April 1, 2018**, as follows:

- The codes being repriced are only those subject to the federal limit on federal Medicaid matching funds for DME.
- Those codes are being priced at the lower of 100% of Medicare or the current Medicaid rate.

DSS plans to make additional MEDS reimbursement changes effective July 1, 2018.

Background

On February 28, 2018, DSS published Provider Bulletin 18-15, which detailed various changes to MEDS reimbursement effective April 1, 2018, in order to ensure that Connecticut's Medicaid program remains in compliance with federal law and to make additional reimbursement changes. On February 27, 2018, DSS published notice for a Medicaid State Plan Amendment (SPA) to implement those changes, with a 30-day public comment period. DSS has analyzed many comments from providers and other stakeholders. On March 16, 2018, DSS met with MEDS providers and other stakeholders to discuss the proposed changes and to hear feedback. As a follow-up to that meeting, on March 20, 2018, DSS sent an Important Message to MEDS providers asking providers to send DSS voluntary cost and other information to enable DSS to conduct a more detailed analysis of MEDS payment rates.

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Details of Payment Changes

In order to ensure that the State complies with federal law and does not lose federal Medicaid matching funds, it is imperative that rate changes to the codes that are subject to the new federal limit be implemented April 1, 2018 and not be delayed further. In consideration of the complexity of the analysis and to help ensure that Medicaid members continue to have access to medically necessary MEDS items, DSS is narrowly tailoring the April 1, 2018 changes to those codes that are subject to the new federal requirements and is increasing the percentage of Medicare that will be paid to 100%.

Therefore, based on additional analysis, including analysis of input from MEDS providers and other stakeholders, effective for dates of service on and after April 1, 2018, the following changes will go into effect for MEDS reimbursement:

- Payment changes apply only to those codes that are subject to the new federal limit on federal Medicaid matching funds based on DSS's analysis of federal law and currently available guidance from the federal Centers for Medicare and Medicaid Services (CMS). Previously, the initial version of the proposal would have applied payment changes to all of the billing codes on all of the MEDS fee schedules, not solely those codes that are subject to the new federal payment limit.

- The rate for those billing codes will change to the lower of 100% of Medicare (including the lowest competitive bid rate) or the current Medicaid rate. This change reflects a substantial increase in payment level from the initial version of the proposal, which would have paid at the lower of 75% of Medicare or the current Medicaid rate.

DSS will be issuing a revised provider bulletin with additional details.

DSS continues to seek input from MEDS providers and other stakeholders on future changes to the billing codes on all of the MEDS fee schedules. DSS plans to make changes to the remaining codes on the MEDS fee schedules effective for dates of service on or after July 1, 2018. As part of that process, DSS is best able to analyze potential changes if providers send detailed information about their costs and other relevant information as requested on March 20, 2018. This information should be submitted through the DSS website located at: http://portal.ct.gov/DSS/Health-And-Home-Care/Reimbursement-and-Certificate-of-Need/DME-Medicaid-Reimbursement. For more information, please refer to the Important Message (IM) titled "Opportunity to Provide

Voluntary Cost Information to Department of Social Services (DSS) to Assist with Reimbursement Analysis" posted on the Connecticut Medical Assistance Program website (CMAP), https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=MEDS+Provider+Reimbursement.pdf&URI=Important_Message%2fMEDS+Provider+Reimbursement.pdf. DSS also welcomes the opportunity to discuss additional potential policy changes related to MEDS.

Overview of the Federal 21st Century Cures Act and Centers for Medicare and Medicaid Services (CMS) Authority

- Effective January 1, 2018, federal law at 42 U.S.C. § 1396b(i)(27), also codified as section 1903(i)(27) of the Social Security Act, as amended by section 5002 of the 21st Century Cures Act, Public Law No. 114-255, places a limit on the amount of federal reimbursement states may receive for certain DME items. Specifically, if any state's annual Medicaid spending for certain DME items, in total, is more than what Medicare would have paid (at its lowest price, including its Competitive Bidding Program), then CMS is required to take back federal matching funds for any amounts more than what Medicare would have paid.

- In implementing this cap effective January 1, 2018, Congress accelerated its original effective date by one calendar year to offset the costs of other Congressional actions. CMS' first formal guidance on the DME cap implementation was delayed until December 27, 2017, giving states only two business days to plan their implementations. Further, CMS' guidance was preliminary; final guidance was not issued until February 2018.

- Given the delayed CMS guidance, the fact that many of Connecticut's Medicaid DME fees are considerably higher than those paid under Medicare's Competitive Bidding Program, and that the State of Connecticut is left with less than a full year to bring its DME spending below the federal cap, the Department opted to publish notice on February 28, 2018 for fee decreases for DME items effective April 1, 2018, in an effort to minimize the ultimate impact of the federal policy upon DME providers and the Medicaid members they serve. The Department also posted policy bulletins on the website on February 28, 2018.

CMS Guidance and the DME Demonstration Analysis

- CMS estimates that Connecticut Medicaid DME spending on billing codes that are subject to the new rule described above (the DME demonstration) exceeded Medicare spending, in total, by $3 million in 2017. If Connecticut keeps paying more than Medicare for 2018, the State will lose federal match on all applicable DME spending where the State paid more than Medicare.

- With an April 1, 2018 effective date, the State needs to meet an annual DME demonstration target for a 12-month calendar year in only 9 months.

- **Any further delay to rate changes for the billing codes subject to the new federal limit would require deeper fee reductions because additional and deeper rate reductions would be required** to make sure the State does not pay more than what Medicare would have paid for DME for calendar year 2018.

- CMS first issued formal guidance on this new rule in very late December 2017, however that guidance was still preliminary. CMS did not provide clarification until several weeks later, putting the State past the January 1, 2018 effective date of the new requirements.

- In addition, in mid-February 2018, CMS revised that guidance, including the method (codes) for calculating the difference between what Medicare would have paid, which increased the amount Connecticut would owe the federal government by approximately an additional $1 million (in addition to the $2 million initial estimate, making the total $3 million).

- Unfortunately, due to this significant delay in CMS guidance, time for internal analysis and 30 days' notice to providers, April 1, 2018 is the very earliest that the rate changes could be implemented.

- Medicare's January 2018 fee schedule rates or competitive bid rates were used to perform the analysis and re-base the revised Medicaid fees.

- Medicaid fees will be re-based annually based on Medicare changes in order to continue to demonstrate compliance with the federal requirements.