American Lung Association.

Medicaid Coverage of Durable Medical Equipment: Basics for People with Asthma

Introduction

Many children and adults with asthma need certain medical devices, such as nebulizers or peak flow meters, to monitor their asthma or deliver medication. The American Lung Association tracks Medicaid coverage of three devices for asthma patients that are important to achieving guidelines-based medical management. In many state Medicaid programs, some or all of these devices are covered under the category of Durable Medical Equipment, or DME. This issue brief explains the Medicaid DME benefit and how this benefit impacts coverage and access to devices for patients with asthma.

Medicaid and the DME Benefit

The Medicaid Program

Medicaid is jointly funded by the states and the federal government, and states have considerable flexibility over many elements of the program. Forty states contract with managed care plans to provide comprehensive coverage to part of their Medicaid populations; nationally, over two thirds of Medicaid beneficiaries are enrolled in managed care plans.[1]

Durable Medical Equipment in Medicaid

The term "durable medical equipment," or DME, is part of a mandatory benefit category in the Medicaid program.[2] By federal regulation, Medicaid programs must cover "medical supplies, equipment, and appliances" for use in the home or other settings, including "items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable."[3]

States have considerable flexibility in defining how they cover DME. States can, but are not required to, maintain lists of preapproved medical supplies and equipment, but they cannot categorically exclude any.[4] Therefore, all states that define asthma-related devices as DME must have some pathway for covering them when medically appropriate, either on the preapproved list or through an opportunity to request exemption.[5] States also have flexibility in how they reimburse for DME: some use fee schedules, often based on Medicare DME payment rates; others pay a "reasonable" charge, or a negotiated rate.[6]

States are permitted to determine the extent of DME coverage they provide, based on medical necessity standards and/or utilization management. Prior authorization and quantity limits, two commonly applied utilization management tools, are discussed in more detail below.

How Beneficiaries Access Devices Covered through the DME Benefit

Generally, an enrollee needs a prescription from a provider in order for DME to be covered by Medicaid. The enrollee must then get the DME from a supplier that is enrolled in the state's Medicaid program. DME suppliers may include mail-order options. Some, but not all, pharmacies are also DME suppliers. Therefore, a patient who needs two different types of product – for example, a vial of albuterol, and a nebulizer to administer it – may need to use a pharmacy and a separate DME supplier.

Medicaid enrollees in managed care plans are entitled to the state's DME benefit. However, managed care plans typically work only with DME suppliers that are in the plan's network. Therefore, enrollees in these plans may have a more limited set of DME suppliers to choose from. Medicaid managed care plans may also apply different prior authorization requirements, quantity limits and other criteria for DME.

Both fee-for-service and managed care enrollees can appeal any denial of coverage for DME. An enrollee faced with an adverse action such as denial of coverage for specific DME would submit a written request for a fair hearing, and in some cases, the Medicaid agency may resolve the coverage issue before a hearing. Each state has an appeals process for its fee-for-service enrollees. Information on fee-for-service appeals should be available on each state's Medicaid website, and a 2018 compilation of appeals processes by state is available.[7] Managed care enrollees can appeal any denial of benefits, including DME, at the plan level; they can appeal further through a hearing system at the state level.[8] Many state fee-for-service programs require that a request for a fair hearing be submitted within 30 days of a notice of adverse action, but others provide more time.[9] Regardless of the state, enrollees are entitled to notification of adverse decisions; scheduled hearings; and the outcome of the hearing.

DME for People with Asthma

Many people with asthma use a range of devices to deliver their medication or monitor their asthma. Commonly used asthma devices that are often considered DME include:

Nebulizers:	Peak flow meters:	Valved-holding chambers:
		
A nebulizer is a device that turns liquid medicine into a mist so that it can be inhaled into the lungs.	A peak-flow meter is a device that allows people to measure how well air moves out of their lungs, to detect narrowing of the airways and manage their asthma.	A valved-holding chamber attaches to the mouthpiece of an inhaler and helps with inhalation of the medication.

In contrast, inhalers for medications like beclomethasone, fluticasone propionate, and others that are sold with specific drugs already integrated are typically included under the pharmacy benefit, not the DME benefit.

The Lung Association tracks barriers to evidence-based asthma interventions in state Medicaid programs. As discussed above, when a device is categorized as DME, Medicaid enrollees may not be able to obtain it at their regular pharmacy, adding a potential barrier to access. The Lung Association found that, in 2019, nebulizers, peak flow meters,

and valved-holding chambers were categorized as DME in the majority of state Medicaid programs (88%, 86%, and 69%, respectively).

Where certain devices are not treated as DME, they may be available through the pharmacy benefit. For example, Michigan's Medicaid program allows all fee-for-service and managed care enrollees to access four spacers or valved-holding chambers per year at a pharmacy, without prior authorization.[10] Other states could consider policies like this to simplify access to devices for enrollees with asthma.

The Lung Association's data also reveals that many state Medicaid programs apply copays, prior authorization requirements, and quantity limits to these devices, potentially further limiting access. The majority of states apply quantity limits to all three types of devices in the study; depending on the specific limit, such restrictions may hinder access for patients who need more than the approved number, such as children who need to keep devices at home and at school. Programs may also require prior authorization, which requires a provider to submit detailed information to the program. While prior authorization is a fairly typical requirement for DME, the process can create more work for prescribers and potential delays or barriers for patients.

Percentage of States in Which Copayments, Prior Authorization, or Quantity Limits are Barriers for Asthma-Related Devices, 2018-2019

	Copay	Prior Authorization	Quantity Limit
Nebulizer	49%	33%	59%
Peak Flow Meter	43%	12%	63%
Valved-Holding Chamber	57%	14%	69%

Source: American Lung Association Asthma Guidelines-Based Care Coverage Project

Medicaid enrollees have several ways to find out whether the asthma devices they need are covered under the DME benefit and how to access them. Their prescriber's office may have this information already. If not, enrollees can reach out to their specific program: the state Medicaid program if they are in fee-for-service, or the managed care plan if they are in managed care. In addition, DME suppliers, including pharmacies that are registered DME providers, may have coverage information available.

Conclusion

For many Medicaid beneficiaries with asthma, important tools such as nebulizers, peak flow meters, and valved-holding chambers are only available through the DME benefit. Providers and beneficiaries should be aware of where and how these devices can be accessed, for both fee-for-service and managed care enrollees. Stakeholders should work with Medicaid agencies and MCOs to identify any policies that create problematic barriers to access for these devices, and consider alternatives that increase access. Good control for people with asthma is at stake.

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2. Kaiser Family Foundation, "10 Things to Know about Medicaid Managed Care" (Dec. 6, 2019). The Medicaid DME benefit is technically part of the home health benefit. Social Security Act Sec. 1905(a)(7). Medicaid programs can also cover some DME for use during physical, occupational, or speech therapy. Section 1905(a)(11) of the Act and 42 C.F.R. §440.110.
3. 42 CFR § 440.70
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