Fiscal Note

Fiscal Services Division

HF 2706 – Repair of Rehabilitation Technology, Medicaid (LSB6374HV)
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Fiscal Note Version – New

Description

House File 2706 provides that under both the managed care and fee-for-service administration of Medicaid, the Department of Health and Human Services (HHS) cannot require a prescription or face-to-face visit for reimbursement of a provider for the repair of complex rehabilitation technology, if the complex rehabilitation technology, as defined in the Bill, was previously prescribed and reimbursed under Medicaid.

Background

The Bill defines complex rehabilitation technology to mean items classified under the Medicare program as durable medical equipment (DME) that is individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living and instrumental activities of daily living identified as medically necessary. Medicare covers medically necessary DME if a doctor or other provider prescribes it for use in a home. The DME that Medicare covers includes but is not limited to blood sugar test strips, continuous passive motion machines, continuous positive airway pressure (CPAP) machines, crutches, home infusion services, hospital beds, infusion pumps, oxygen equipment, patient lifts, walkers, wheelchairs, and scooters. However, not all of these would be covered under the Bill, because they would not all be classified as complex rehabilitation technology that is individually configured, per the definition in the Bill.

Assumptions

- According to the HHS, 1,701 previously denied pieces of technology could be reimbursed because of the Bill, at an average cost per unit of $47.45.
- According to the HHS, there would not be fewer appointments realized from the Bill due to existing rules not mandating an appointment.
- For State FY 2025, the State share for provider reimbursement is approximately 36.5%, which is a blended Federal Medical Assistance Percentage (FMAP) rate consisting of 25.0% of the FFY 2024 FMAP rate and 75.0% of the FFY 2025 FMAP rate. In FY 2025, provider reimbursement is expected to cost $81,000 total, with the State paying $29,000 and the federal government paying $52,000.
- For State FY 2026, the State share for provider reimbursement is approximately 36.8%, or the State share of FY 2025 Medicaid costs via the FMAP rate. In FY 2026, provider reimbursement is expected to cost $81,000 total, with the State paying $30,000 and the federal government paying $51,000.
- According to the HHS, a Medicaid Management Information System (MMIS) contract amendment to properly identify claims and pay at enhanced rates is necessary to administer the Bill, costing $62,000 in FY 2025 (600 programming hours at $103 per hour), with the State paying 25.0% and the federal government paying 75.0%.
- An increase in the General Fund appropriation to the HHS for Medicaid will be necessary to pay for costs in the Bill.

Fiscal Impact

House File 2706 is estimated to increase costs to the State by approximately $44,000 in FY 2025 and $30,000 annually beginning in FY 2026.

Figure 1 — Total Costs of Reimbursement — Repair of Complex Rehabilitation Technology

Medicaid Costs	FY 2025		FY 2026	
	Total	State	Total	State
Provider Reimbursement	$ 81,000	$ 29,000	$ 81,000	$ 30,000
MMIS Core Contract	62,000	15,000	0	0
Total Costs	**$ 143,000**	**$ 44,000**	**$ 81,000**	**$ 30,000**

Sources

Iowa Department of Health and Human Services
Centers for Medicare and Medicaid Services
Legislative Services Agency analysis

/s/ Jennifer Acton

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The fiscal note for this Bill was prepared pursuant to Joint Rule 17 and the Iowa Code. Data used in developing this fiscal note is available from the Fiscal Services Division of the Legislative Services Agency upon request.