MEDPAC Medicare Payment Advisory Commission

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November 30, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Competitive Bidding Product Categories

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) plan to add new product categories into the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program (CBP). We appreciate your staff's continuous efforts to administer and improve Medicare's payment policies, particularly given the competing demands on the agency.

Medicare's method of setting payment rates for DMEPOS products varies by whether an item is included in the CBP. Medicare pays for items not included in the CBP using a fee schedule that is largely based on supplier charges from 1986 to 1987 (updated for inflation) and undiscounted list prices. Medicare pays for items included in the CBP based on competitively determined payment rates, referred to as single payment amounts, if a beneficiary lives in a competitive bidding area (CBA). For those same items furnished to beneficiaries residing in non-CBAs, Medicare's payment rates are based, at least in part, on competitively determined rates. To date, CMS has included a broad range of products in the CBP, including items such as power wheelchairs, walkers, diabetes testing supplies, continuous positive airway pressure (CPAP) devices, and oxygen equipment.

New product categories to be added for the next round of the CBP

CMS plans to add ventilators, off-the-shelf (OTS) back braces, and OTS knee braces in all CBAs in the next round of the CBP. These products are currently not included in the CBP and are instead paid on a fee schedule basis.

Comment

The CBP has successfully driven down the cost of DMEPOS products for the Medicare program and beneficiaries and has been an important tool to combat fraud and abuse. CMS has also taken

steps, through efforts such as its health status monitoring program, to ensure continued access to needed DMEPOS products. Based on the results of the health status monitoring program, CMS has said that no negative changes in beneficiary health outcomes have resulted from the CBP. For these reasons, the Commission supports adding more products into the CBP.

Adding more products into the CBP is consistent with the Commission's long-held support of payment accuracy in fee-for-service (FFS) payment systems. DMEPOS payment rates should be set to ensure beneficiary access to needed products and to encourage efficient provision of the products. However, rates for products that are not part of the CBP are often based on outdated and inflated pricing information (e.g., 30-year-old supplier charges and unadjusted list prices). Setting payment rates too high creates incentives for higher volume, imposes financial burdens on beneficiaries and taxpayers, and raises program integrity issues. Indeed, many of the products CMS plans to add to the CBP appear to have excessive payment rates and utilization patterns that exhibit signs of potential fraud and abuse:

- *Excessive payment rates.* The Commission has found that Medicare's payment rates for OTS orthotics, a category of products that includes OTS knee and back braces, are substantially higher than rates paid by private payers. We found that, in 2015, Medicare's payment rates, relative to private payers, ranged from 20 percent to 50 percent higher.[1]

- *Rapid spending growth*. The Office of Inspector General (OIG) has raised concerns about the rapid increase in Medicare billings for ventilators. The OIG found that Medicare paid 85 times more claims for noninvasive pressure support ventilators in 2015 than it did in 2009, leading to a rapid increase in expenditures.[2] For OTS orthotics, Medicare and beneficiary spending grew from approximately $255 million in 2014 to $678 million in 2017, an average growth rate of 38 percent per year. OTS back and knee braces account for roughly three quarters of that spending, and their expenditures have also increased rapidly. For example, from 2014 to 2017, Medicare and beneficiary expenditures for one back brace product (L0650) increased from $46 million to $257 million, an average growth rate of 77 percent per year.

- *Potential fraud and abuse*. Based on an examination of the suppliers that furnished and clinicians who ordered a back brace product whose spending has grown rapidly, the Commission has raised concerns that a meaningful portion of the increased use of OTS orthotics since 2014 could represent supplier-induced demand or even potential fraud and abuse, likely involving aggressive marketing, telehealth companies, and clinicians ordering braces for beneficiaries with whom they have little or no clinical relationship. For example, in 2016, about 50,000 clinicians ordered at least one of the back braces we examined, but the top 25 clinicians were responsible for ordering 20 percent of all such braces for the entire Medicare FFS population.[3] These 25 clinicians ordered braces for beneficiaries from across the

[1]Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[2]Office of Inspector General, Department of Health and Human Services. 2016. *Escalating Medicare billing for ventilators raises concerns.* Washington, DC: OIG.
[3]Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

country and almost never billed Medicare for any other services for these beneficiaries, suggesting that these clinicians' main interaction with the beneficiaries was to order braces. These types of practices likely expose beneficiaries to harassment, as has been documented in numerous news stories, and could prohibit a beneficiary from receiving a needed brace in the future, given the limits on how frequently Medicare will pay for the same type of brace.

In addition to supporting the inclusion of OTS knee and back braces in the CBP, the Commission believes CMS should also add other OTS products, such as wrist, ankle, and shoulder orthoses. CMS already has the authority to add these products to the CBP. In addition, excluding these OTS products while including OTS knee and back braces could result in abusive billing practices shifting from knee and back braces to other OTS products. Medicare rates for other OTS products substantially exceed private payer rates, and the utilization and spending associated with such products have grown rapidly. For example, from 2014 to 2017, Medicare and beneficiary expenditures for an OTS walking boot (L4361) increased from $11 million to $42 million, an average increase of 55 percent per year.

As CMS adds OTS products to the CBP, the agency should monitor whether suppliers shift their utilization from OTS products to custom-fitted products, which are prefabricated products that require substantial modification by a trained practitioner. (The need for substantial modification by a trained practitioner distinguishes them from OTS products, which are often identical prefabricated products that require only minimal self-adjustment.) While not all suppliers have the ability to custom-fit orthoses, suppliers who do will have an incentive to bill for custom-fitted orthoses once OTS products are added to the CBP because Medicare's payment rate for OTS products will likely decline under the CBP while payment rates for custom-fitted products will remain unchanged. To address this issue in the future, CMS could bid out all prefabricated orthoses, including OTS and custom-fitted products, and only allow bids from suppliers with the ability to offer the entire suite of products, thereby mitigating the incentive for a supplier to furnish one type of orthosis because they cannot furnish another type.[4] However, CMS likely would need additional legislative authority to include custom-fitted orthoses in the CBP. In the absence of any additional authority, CMS could take other steps, such as instituting prior authorization or targeted audits, to ensure that beneficiaries actually need custom-fitted products and that suppliers are not billing inappropriately. In the past, the OIG has found that many suppliers did not provide fitting and adjustment services even when they billed for Healthcare Common Procedure Coding System (HCPCS) codes that include both the brace itself and fitting and adjustment services.[5]

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on DMEPOS policy issues, and we look forward to continuing this relationship.

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[4]Such a bid process would have the added benefit of more accurately pricing custom-fitted orthoses, whose payment rates are still largely based on supplier charges and list prices.

[5]Office of Inspector General, Department of Health and Human Services. 2012. *Medicare supplier acquisition costs for L0631 back orthoses*. Washington, DC: OIG.

If you have any questions regarding our comments, please do not hesitate to contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman