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Francis J. Crosson, M.D., Chairman  
Jon B. Christianson, Ph.D., Vice Chairman  
James E. Mathews, Ph.D., Executive Director

July 2, 2018

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

**RE: File Code CMS-1687-IFC**

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period entitled “Medicare Program; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas,” *Federal Register*, vol. 83, no. 92, p. 21912 (May 11, 2018). We appreciate your staff’s continuous efforts to administer and improve Medicare’s payment policies for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), 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 Competitive Bidding Program (CBP) and where a beneficiary resides. 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 one of 99 specified urban areas, referred to as competitive bidding areas (CBAs). For those same items furnished to beneficiaries residing in non-CBAs, Medicare’s method of setting payment rates has varied over time. Through 2015, Medicare paid historical fee schedule rates. In 2016, CMS began paying for such products using information from the CBP; specifically, Medicare paid a 50/50 blend of historical fee schedule rates and rates derived from the CBP. From 2017 forward, Medicare has paid rates that are 100 percent derived from the CBP.

**Transition period for phase-in of fee schedule adjustments**

This interim final rule reinstates 50/50 blended payment rates for rural and non-contiguous non-CBAs from June 1, 2018, through December 31, 2018. The rule notes that CMS is continuing to evaluate broader changes to the fee adjustment methodology for items furnished in non-CBAs beginning January 1, 2019.

CMS asserts that the higher, blended payment rates are necessary to ensure access to DMEPOS products. While the agency notes its fee adjustment impact monitoring data do not indicate an increase in adverse health outcomes, CMS states that the system does not monitor other important trends (e.g., whether suppliers are struggling to maintain current service levels) and may not be able to detect rapidly emerging trends.

*Comment*

The Commission does not support CMS's proposal to broadly reinstitute the blended payment rates as indicated in the interim final rule. The comments below reflect the Commission's position both with respect to the specific changes posed for the second half of 2018, as well as to any changes CMS may be contemplating for 2019 and beyond.

The CBP has successfully driven down the cost of DMEPOS products and has been an important tool to combat fraud and abuse. Medicare's payment rates for some of the highest expenditure DMEPOS products have fallen by an average of roughly 50 percent since the implementation of the CBP in 2011, and program spending and beneficiary cost sharing have declined accordingly. In contrast, Medicare spending on DMEPOS products excluded from the CBP has continued to grow. In addition, the Commission has found that fee schedule payment rates for many products excluded from the CBP appear to be excessive, which increases spending for the Medicare program and beneficiaries, and can encourage the type of fraud and abuse that was more pervasive before CMS implemented the CBP. For example, for the highest expenditure off-the-shelf orthotic product (which is currently excluded from the CBP), the Commission has found that Medicare's fee schedule rate was roughly 30 percent higher than private payer rates in 2015; Medicare expenditures for the product increased by over 300 percent from 2014 to 2016; and the product's utilization patterns suggest the presence of potential fraud and abuse.<sup>1</sup>

In addition to supporting fiscal discipline, the Commission believes beneficiaries should have access to all medically necessary DMEPOS products. To that end, we are encouraged that CMS said its fee adjustment impact monitoring data have not shown any negative trends in several key secondary indicators of access to DMEPOS products, such as mortality and emergency room visit rates, in non-CBAs since CMS began adjusting fee schedule rates based on CBP rates. While CMS has observed no negative trends in outcomes, we understand the agency is concerned about a reduction in the number of suppliers, access issues that may occur in the future, and other trends CMS does not monitor. If CMS determines that payment rates in non-CBAs should be increased to maintain access to medically necessary DMEPOS products, the Commission believes that the increases should be limited and targeted, and CMS should consider taking steps to offset the cost of higher payment rates.

Any payment increase should be limited to the amount necessary to ensure access to medically necessary DMEPOS products. Returning to a 50/50 blend of historical fee schedule rates and CBP-derived rates will result in large payment increases, often of 50 percent or more. These large increases are in addition to other payment rate adjustments CMS has already made to protect

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<sup>1</sup> Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

access, such as an increase of roughly 10 percent in rural non-CBAs.<sup>2</sup> While we understand CMS continues to study supplier costs in non-CBAs in accordance with its mandate under the 21<sup>st</sup> Century Cures Act, the interim final rule does not present supplier cost data that could be used to justify the magnitude of the payment increase. As CMS continues to evaluate DMEPOS payment rates for 2019 and beyond, we encourage the agency to use the best available data to determine whether costs that suppliers must necessarily incur are higher in non-CBAs relative to CBAs and, if so, whether an adjustment smaller than the one discussed in the interim final rule would be sufficient to ensure access.

Any payment increase in non-CBAs should be directed only to products that exhibit signs of potential access problems. The cost of DMEPOS products themselves likely do not vary substantially across geographic areas, but other costs might (e.g., delivery or personnel costs). Therefore, depending on the nature of the product, the total cost associated with furnishing a product may or may not vary substantially across geographic areas, and the magnitude of that variation might also be different across products.

Similarly, any payment increase in non-CBAs should be directed only to areas that exhibit signs of potential access problems. Non-CBAs include a wide variety of areas, ranging from moderate-size urban areas to remote rural areas. An identified potential access problem in a rural or non-contiguous area should not be used as a basis to increase payment rates across all non-CBAs. The issues faced by suppliers in rural and non-contiguous areas are likely different from those faced in urban non-CBAs, many of which are metropolitan statistical areas with populations of 250,000 or more. Furthermore, if the agency has concerns about payment rates in urban non-CBAs, CMS has better ways to establish appropriate payment rates than applying a large, across-the-board payment increase. For example, CMS could set payment rates in moderate-size urban non-CBAs by expanding the CBP to include those areas and use the information from those competitions to help set payment rates in smaller non-CBAs.

To the extent that CMS must raise payment rates in non-CBAs to ensure access, the agency should consider offsetting the increased costs by further expanding the products included in the CBP. In the interim final rule, CMS estimates that increasing payment rates in rural and non-contiguous non-CBAs for the 7-month period from June 1, 2018, to December 31, 2018, will increase spending by \$360 million—\$290 million for the Medicare program and \$70 million for beneficiaries. CMS could use its current statutory authority (and seek additional legislative authority where necessary) to expand the CBP to offset these increased burdens for beneficiaries and the program. In our June 2018 report to the Congress, we noted our support for shifting additional products into the CBP and highlighted several DMEPOS products for which savings would likely be generated if they were included in the CBP.

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<sup>2</sup> The fully adjusted fee schedule amount for rural areas is set at 110 percent of the national average regional single payment amount. Therefore, the actual increase may be higher or lower than 10 percent in specific areas.

Seema Verma  
Administrator  
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## **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.

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,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." The signature is written in a cursive style with a large initial 'F' and a distinct 'M.D.' at the end.

Francis J. Crosson, M.D.  
Chairman