Congress Must Stop Drastic Cuts to DME Items in Rural Areas—Support S. 2736

Background

Currently, 100 of the largest, most densely populated MSAs in the country are participating as Competitively Bid Areas (CBAs) in the Competitive Bidding Program (CBP) for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies). These CBAs are home to 58% of all Medicare beneficiaries in the nation.

Durable medical equipment (DME) suppliers, often called home medical equipment (HME) suppliers, competed for a limited number of contracts to serve Medicare beneficiaries residing in these CBAs through an auction program that awarded contracts to those with the lowest bid amounts, resulting in a drastic reduction in competition for suppliers and opportunity to increase market share. Nearly 75% of bids submitted to care for the entire Medicare population in these respective CBAs were not contracted, leaving a small fraction of suppliers to meet the needs of this large group of beneficiaries.

On October 31st, 2014, the Centers for Medicare & Medicaid Services (CMS) released the final rule *on "Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies",* which established the methodology for making national price adjustments to the fee-for-service payments of specified HME, enteral nutrition, & related services paid under fee schedules. On January 1, 2016, CMS began the first phase of a two part reimbursement adjustment that applies pricing derived from these highly populated CBAs to all areas of the country without exception for rural America.

How CMS is Implementing Pricing Nationwide

For qualified HME items, the final rule phases in a new reimbursement rate for non-CBAs over 6 months that began January 1, 2016. CMS divided up the continuous 48 states into eight distinct regions. An unweighted average of all of the Single Price Amounts (SPAs) from high population CBAs within each region were used to determine the Regional Single Price Amount (RSPA) for each affected product.

Claims with dates of service from January 1, 2016 through June 30, 2016 are now based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the RSPA adjusted fee schedule. Starting on July 1, 2016, reimbursement rate will be 100% of the RSPA adjusted fee schedule amount. The following are estimated examples of these drastic cuts –

HCPCS Code	Region	12/31/15	1/1/16 Rate	7/1/16 Rate
K0003 (standard wheelchair)	MidEast	$93.40	$65.64 **(-30%)**	$37.89 **(-59%)**
E0601 (CPAP)	Far West	$105.33	$75.93 **(-28%)**	$46.53 **(-56%)**
K0823 (standard PMD)	New England	$577.42	$428.48 **(-26%)**	$279.55 **(-52%)**
E1390 (O2 concentrator)	Great Lakes	$180.92	$135.82 **(-25%)**	$90.71 **(-50%)**
E0143 (walker with wheels)	SouthEast	$107.19	$80.22 **(-25%)**	$53.25 **(-50%)**

The RSPAs are still bound to a national average that cannot vary more than 10% above or below the combined, unweighted average of all RSPAs in the country. As such, any area with a RSPA that is greater than 110% of the national average will be adjusted downward. Further, even the most remote, rural areas will be bound to the national ceiling or 10% above the RSPA at CMS' discretion even though costs may far exceed that of the high-population CBAs of which the prices were derived.

The Risk to Rural America

The first phase of implementing these new payment rates, set by applying CMS' flawed competitive bidding process to non-CBAs, took effect January 1, 2016. Six months is not enough time to monitor disruption in Medicare beneficiaries' access to the DME items they need. Implementing the second phase on July 1, 2016 will only exacerbate complications and beneficiary harm.

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- **Rural America has unique attributes that have distinct costs that differ from their urban counterparts.** The HME Industry has convincing data that indicated providing DME items in rural areas have higher costs in order to access, care for, and support non-urban and rural beneficiaries, which are *not accounted for* in the RSPAs, such as:
  - Employee time, fuel costs, and mileage to drive to the beneficiary's residence
  - Widely ranging geological and road characteristics that could require specialty vehicles, including 4 wheel drive, ATVs, tractors, snowmobiles, ferry coordination, and more
  - Sparsely populated areas that don't offer the same routing efficiencies as dense urban areas
- **Suppliers in non-CBAs will not have economies of scale to offset the drastic payment cuts.** In CBAs, suppliers try to offset the significant payment cuts through increased volume of beneficiaries while supplementing payments with serving markets outside the CBA. However, under this forthcoming mandate to expand the program nationally, suppliers in non-CBAs will receive the same drastic payment cuts set in CBAs, without exclusive contracts and increase in volume of business or the ability to compensate with higher rates outside of the CBA.

CMS' final rule also limits the bid ceiling for future rounds of competitive bidding to payment rates set by previous rounds of bidding. Currently, bid limits are set by the fee schedule, which allows for adjustments for inflation. CMS has indicated that it plans to continue competitive bidding for DME items far into the future with each new round being capped at the previous SPA. This price-setting mechanism by CMS fails to follow Congress' intent to find true market-driven prices for home medical equipment by failing to factor:

- **Medical inflation continues to rise**, yet decreasing the bid ceiling limit over many years will set artificially low rates. This will hamper competition.
- **Timely beneficiary access to quality goods and services will be compromised** since the artificial, mandatory lowering of prices each round will dip below the true market cost of caring for beneficiaries. This artificial price reduction also fails to account for new product innovations, disease management therapies, and changing economic factors that contribute to the cost of care.
- **Long term, CMS' approach of mandating lower caps in each round eventually result in government-induced caps that are below costs for suppliers** to provide items and services. Congress' intent was for CMS to save money compared to the unadjusted fee schedules, not to force prices below the true market value through subsequent rounds of bidding with increasingly lower ceilings.

Solution

AAHomecare strongly supports legislation introduced by Senators John Thune (R—SD) and Heidi Heitkamp (D—ND) that will provide more time for Congress to evaluate the effects of the first rate reduction from January 1, 2016 on beneficiary access and instill safeguards into the Competitive Bidding program. S 2736 "Patient Access to Durable Medical Equipment Act of 2016" creates a softer landing that mitigates the unintended consequence of market collapse under CMS' current expansion plans by including the following language:

For all DMEPOS in non-competitive bidding areas, the Secretary must:

- **Delay the second cut for Home Medical Equipment items in non-bid areas by fifteen months,** moving the date for of phase two of implementation from July 1, 2016 until at least October 1, 2017.
- **Establish in statute the bid ceiling for Competitive Bidding contracts that begin on or after January 1, 2019 at the unadjusted fee schedule payment rate as of January 1, 2015** with yearly CPI adjustments.
- **Instruct CMS to revisit pricing adjustments for non-bid areas** taking into account travel distance, clearing price, and other associated costs with furnishing equipment for prices taking effect January 1, 2019.
- **Advance the start date** of the federal portion of reimbursement mirroring Medicare rates by three months from calendar year 2019 (January 1) to fiscal year 2019 (October 1, 2018).

Our Ask:

AAHomecare strongly urges Senators to co-sponsor S 2736 that will provide relief for homecare patients and providers in non-competitive bidding areas.