April 6, 2017

Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert Humphrey Building  
200 Independence Ave. SW  
Washington, D.C. 20201

Re: Stakeholder Input for Adjusting Payments to DMEPOS Suppliers in Non-Competitive Bidding Areas (Non-CBAs)

Dear Administrator Verma:

The Advanced Medical Technology Association (AdvaMed) is writing to provide input for responding to the 21st Century Cures Act provision mandating that the Secretary seek input from stakeholders on the methodology CMS uses for applying single payment amounts determined under the Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to payments in areas of the country not subject to competitive bidding (non-CBAs). Specifically the Secretary is required to take into account the highest amount bid by a winning supplier in a CBA and comparing the following between non-CBAs and CBAs: average travel distance and cost associated with furnishing items and services in an area; average volume of items and services furnished by suppliers in the area; and the number of suppliers in the area.

AdvaMed is pleased to comment on these matters. AdvaMed member companies produce the medical devices and technologies that are covered under Medicare’s DMEPOS benefit. These devices and technologies play a critical role in allowing beneficiaries to lead healthy, productive, and independent lives in their homes and communities, thereby serving to fulfill the intent of Congress when it created this benefit.

Providing DMEPOS in non-CBAs

With regard to CMS’s methodology for applying single payment amounts (SPAs) to non-CBAs, AdvaMed would first like to observe that SPAs used in CBAs have been determined under a set
of circumstances unique to each of those areas and which bear little, if any, relationship to the areas in which they would be applied. In addition, the Competitive Bidding Program has produced a limited number of contract suppliers in each CBA and these suppliers have presumably taken into account in their bids an increase in their market share of Medicare beneficiaries if selected as a winning bidder.

In applying SPAs to non-CBAs, CMS will be starting with payment information based on a dynamic that does not apply to the area. Furthermore, CMS will not be limiting the number of contract suppliers through a competitive bidding process, and, therefore, suppliers cannot expect a larger market of beneficiary customers. Without a larger market for their services, suppliers in non-CBAs can be expected to incur higher costs for serving Medicare beneficiaries than contract suppliers in areas subject to competitive bidding.

Furthermore, additional resources are very often required to provide the same level of service to beneficiaries living in rural areas. The cost of delivering service in less dense and remote geographic areas is higher than in urban areas due to increased travel time for delivery and set-up. For similar reasons, costs are higher for equipment trouble shooting or replacement during rural beneficiaries’ use of DMEPOS service. In addition, rural suppliers must often rely on third-party couriers and shippers for delivery, incurring higher costs in the process.

These higher costs incurred by rural suppliers become critical when considering the October 2016 findings of the study, Analysis of the Cost of Providing Durable Medical Equipment to the Medicare Population: Measuring the Impact of Competitive Bidding by Dobson, et al. This study found that, on average, all DMEPOS included in its survey were reimbursed at 88 percent of overall cost. One result of the program not covering actual costs incurred by suppliers participating in the program has been fewer suppliers available to serve Medicare beneficiaries. From January 2016 through October 2016, the number of suppliers participating in the program has decreased by 23 percent. We believe this reduction is the direct result of the adjustment methodology used by CMS for payments in non-CBAs.

The Dobson study also observes that the quality of service in rural areas is particularly threatened by payments not covering costs. “This is because rural areas do not have the population density to win exclusive contracts, or make up for the revenue cost differential through volume. “ The study notes that even larger companies are limiting services to rural areas by closing rural locations, limiting services areas, and/or offering fewer deliveries per month.

To address the special cost problems faced by suppliers providing service to Medicare beneficiaries, AdvaMed recommends that CMS incorporate add-on payments to amounts that suppliers would otherwise receive under CMS adjustment process methodology. One way to do so would be to use add-on payment policies similar to those currently used for ambulance services paid by Medicare. For ambulance services, CMS uses geographic categorization (urban, rural, super-rural) of the point-of-pickup zip code attached to each ambulance transport. Urban and rural zip codes are defined generally as those located inside (urban) or outside (rural) of a metropolitan statistical area. Super-rural zip codes are unique to the ambulance fee schedule and are defined as those which are located in a rural county that is among the lowest quartile of all rural counties, by population density.
AdvaMed also recommends consideration of another special payment policy for suppliers providing service to rural beneficiaries. Currently CMS uses a special rule for rural areas for items included in more than 10 CBAs. CMS could supplement this special rule by making it more generous, and also applying the national ceiling prices in areas with a limited number of suppliers or low average volume of Medicare business. For example, the national ceiling amount could apply to areas with low volume of Medicare business or to suppliers meeting a low numerical threshold – for instance, the lowest quartile based on volume of a particular DMEPOS item or number of suppliers in an area, or some other similar numerical threshold. This would help boost payment levels in other markets, and not just rural ones. Alternatively, or in addition, CMS could also establish an add-on payment for these defined low volume or low supplier areas, based on its general approach used for rural areas in the ambulance fee schedule. This would involve increasing the base payment by a percentage amount, such as 10 percent.

We thank you for the opportunity to offer these comments. If you have any questions, please contact, Richard Price at 202-434-7227 or rprice@advamed.org.

Sincerely,

Donald May
Executive Vice President,
Payment and Health Care Delivery