June 14, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1687-IFC
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: 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—Interim Final Rule with Comment Period

Dear Administrator Verma:

The Advanced Medical Technology Association (AdvaMed) appreciates the opportunity to provide comments on the Interim Final Rule with Comment Period regarding resumption of the transitional 50/50 blended rates for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries residing in rural and non-contiguous areas not subject to competitive bidding. 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.

Resuming Transitional Blended Fee Schedule Rates in Rural and Non-Contiguous Areas

AdvaMed applauds CMS' decision to resume the blended rates in rural and non-contiguous areas. We recommend, however, that the timeline for the transition’s blended rates be extended for an additional 6 months beyond December 31, 2018. We also
recommend that the blended rates apply in all parts of non-CBAs and not just rural and non-contiguous areas.

In our April 6, 2017 letter to the Administrator, AdvaMed had argued for extending the period of application of transitional blended fee schedule rates in all non-competitive bidding areas (non-CBAs). We did so for many of the same reasons that CMS now finds compelling for resuming the blended rates in a portion of non-CBAs, specifically rural and non-contiguous areas. These reasons include lower volume of items and services furnished per supplier in non-CBAs, decreasing numbers of suppliers in non-CBAs that leads to compromised beneficiary access to necessary items and services, and questions about the financial ability of suppliers in non-CBAs to continue to serve beneficiaries, when some of them have seen payment reductions of up to 60 percent on average from the full fee schedule adjustments. We note that supplier participation in Medicare continues to fall at an alarming rate. Between November 10, 2017, and January 18, 2018, the number of unique DMEPOS supplier companies declined across all States by 33.1 percent, from 9,769 to 6,538, and the number of DMEPOS locations declined by 30.9 percent, from 14,066 to 9,716 over the two-month period.

While AdvaMed supports CMS' decision to resume the blended rates in rural and non-contiguous areas, we also recommend that the timeline for the transition's blended rates be extended for an additional 6 months to give CMS more time to discover and assess the impact resumption of blended rates have on the problems CMS identifies as existing in non-CBAs. Further, if blended rates are not extended beyond the proposed expiration date, AdvaMed recommends that CMS allow the blended rates to remain in effect for beneficiaries who receive service under the blended rates prior to December 31, 2018, and for the duration of their therapy that may extend beyond the end date for the blended rates as specified in the Interim Final Rule.

We also believe that the concerns detailed in the preamble resulting from CMS' adjustment methodology apply equally to all areas of non-CBAs, and not just rural and non-contiguous areas. CMS suggests in the preamble that it has limited the resumption of the blended rates to rural and non-contiguous rates out of budgetary concerns and not on the basis of evidence that only rural and non-contiguous areas have experienced the problems cited above. We believe that these problems exist throughout non-CBAs and that blended rates should apply in all parts of these areas.

To address the special cost problems faced by suppliers providing service to Medicare beneficiaries in all non-CBAs, AdvaMed hopes that the next round of competitive bidding will provide a mechanism for ensuring that payments accurately reflect the cost of serving patients in non-CBAs. One method 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.
Another approach would be to establish a 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. 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.

Finally, while the preamble recognizes that the Interim Final Rule is necessary to promote stability in rural and non-contiguous areas and enables CMS to work with stakeholders to preserve beneficiary access to DMEPOS, it is only temporary solution. AdvaMed encourages CMS to continue to work with stakeholders to reform the competitive bidding program to ensure stability and beneficiary access.

**Excessive Payment Reductions for Oxygen**

The preamble to the Interim Final Rule points to an unintended consequence of combining two adjustments--application in non-CBAs of a budget neutrality offset for stationary oxygen equipment due to increased spending for portable oxygen equipment and application of the methodology implemented by CMS for fee schedule adjustments for payments for all products not subject to competitive bidding. The combined impact of these adjustments has resulted in payment amounts for stationary oxygen equipment in CBAs being higher than the adjusted fee schedule amounts in some rural and non-contiguous where competitive bidding has not taken place. CMS concludes that payment at the blended rates would avoid these situations where payment for furnishing oxygen in a rural or non-contiguous, non-CBA is lower than payment for furnishing oxygen in a CBA.

What is not discussed in the rule is how this temporary solution addresses the problem beyond the expiration of the blended rates at the end of 2018. AdvaMed believes that the application of budget neutrality offset to adjusted rates is inappropriate, since the rates in non-CBAs are based on competitive bidding single payment amounts and, as the preamble points out, the budget neutrality requirement does not apply under the Competitive Bidding Program.

In addition, AdvaMed believes that separating the current oxygen and sleep product category in the Competitive Bidding Program will further stabilize the process for determining rates for critical home-based respiratory care equipment. Home oxygen and home sleep equipment and services are distinct types of products and combining the two product categories into one has allowed suppliers providing only one product type to deflate the rate for the one they do not provide. Oxygen and sleep products should therefore be separated into distinct categories for bidding purposes and for adjustment of single payment amounts in non-CBAs.
We appreciate this opportunity and please do not hesitate to contact me or Richard Price, Senior Vice President, Payment & Health Care Delivery Policy at AdvaMed (rprice@advamed.org) if you have any questions.

Sincerely,

Donald L. May
Executive Vice President
Payment & Health Care Delivery Policy
AdvaMed