



April 5, 2017

Via Electronic Mail: DMEPOS@cms.hhs.gov

Joel Kaiser, Director
Division of DMEPOS Policy
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act

Dear Mr. Kaiser:

The American Association for Homecare (AAHomecare) appreciates the opportunity to provide comments on the DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act. AAHomecare represents DME providers and manufacturers with over 3,000 locations nationwide.

As the national Association that represents the durable medical equipment industry, we believe we have a unique perspective on the issues and challenges with applying competitive bidding single payments amounts (SPAs) to non-CBA areas.

As a matter of background, AAHomecare provided comments on the CMS proposed rule in 2014. In those comments, we expressed significant concerns regarding:

- CMS establishing the single payment amounts (SPAs) at the median rather than the market clearing price (*e.g.* the highest price in the array of bids that would meet expected capacity).

Under the median bid logic, fifty percent of all winning bidders are actually being asked to accept a contract to provide goods and services at a rate below what they felt was reasonable and affordable. Using the “median price” methodology creates a financially unsustainable bid program since half the contract suppliers are paid less than their best price. In addition, utilization of these same competitive bidding SPA rates which are based on median winning bids to adjust Medicare reimbursement outside of CBAs only exacerbates the challenges this logic has created in ensuring that beneficiaries have access to the quality goods and services they need and places the infrastructure of an important part of the health care continuum of care at risk.

- CMS accepting bids from bidders that did not meet the minimum requirements of the program, such as having a valid license in the state where they bid. We believe CMS violated its own rules by accepting bids from unlicensed bidders and using those bids to calculate SPAs. CMS has taken action against some unlicensed bidders, but has not revised the SPAs to exclude bid information from unlicensed bidders. As a result, the SPAs in those CBAs are flawed and cannot be fairly applied to adjust Medicare payment amounts in other areas.
- CMS accepted bids, and awarded contracts, from bidders that had no legitimate physical access to the bid area; had no intention of establishing a physical location in proximity to the bid area; and, had no real intention of actively servicing and supporting the bid area. Again, this action has produced SPAs that are flawed and should not be used to adjust Medicare payment rates to other non-bid areas.

We recognize that competitive bidding can lower payment amounts, but we believe there is no credible evidence that the program has in fact met its goal of protecting beneficiary access to the quality DMEPOS equipment and services that they need. The program has not been sufficiently evaluated to determine its effects on beneficiary access and the quality of equipment that is being furnished, within competitive bid areas. As such, the application of questionable, winning bid rates from large urban bid areas to small urban / suburban areas and rural areas seems arbitrary, capricious, and an abuse of discretion.

We have historically asked that CMS use the market clearing prices, instead of the SPAs created from median winning bids, as the starting point when calculating prices in non-CBAs, as these numbers represent true market pricing. Additionally, we ask that CMS adjust the market clearing prices upward to account for the unique aspects of doing business in non-bid and rural areas. It is much more difficult to service rural areas because suppliers have lower patient volumes to offset any competitive bidding price reductions. In addition to lower patient volume, patient density is a much greater challenge in rural areas. There are considerably more miles and time between patients in the rural setting, increasing costs associated with service and delivery. Further, suppliers in these areas do not typically have the same buying power because of the generally lower patient volumes. Finally, the fundamental flaw is applying the SPA rates from large, urban bid areas to non-bid areas in the absence of the volume pricing incentive that exists for winning bidders. Winning bidders are granted exclusive rights to service the Medicare population of a defined geographic area for a defined set of goods, thereby giving them a reasonable expectation of greater volume of business in return for accepting a lower payment rate. In contrast, applying SPA rates to non-bid areas arbitrarily cuts supplier reimbursement with no possibility of greater volume to offset the lower payment rate.

CMS failed to consider cost variance based on geographic area and should have taken this into consideration when rolling out CB pricing in non-CB areas. The most significant variables that affect costs are labor rates, transportation, population density, miles and time between points of service and regulatory costs. For example, suppliers in states where professional staff must perform certain services; such as CPAP setups, have a higher cost of doing business compared to suppliers in states that

don't have these requirements. Additionally, a rural supplier's time and miles between points of service will likely be a multiple (two, three, four times or more) of what it would be in an urban area.

The Medicare competitive bidding program has systematically skewed bid prices downward. Consequently, SPA data from the CBAs are unreliable and cannot be applied to areas outside the CBAs. Pricing data from one CBA cannot be used to adjust Medicare payment in another state unless those differences are accounted for.

The SPAs from many CBAs were based on bids submitted by out-of-state or area suppliers who either were not aware of the costs of doing business in the CBA or did not invest the time and resources to meet the state's regulatory requirements. State licensing and other regulatory requirements for DMEPOS suppliers can serve as a measure of the cost of doing business in a state. State licensing statutes will specify requirements for professional staff, physical plant, and provider quality standards that often exceed those required nationally under the Medicare program. We believe that suppliers that do not meet these requirements at the time they submit a bid are more likely to submit a lower bid than licensed suppliers because they are not aware of the costs of doing business in a state.

For areas outside the contiguous United States, manufacturer members have reported to us that suppliers in those areas are responsible for all freight charges for the equipment they buy. Within these areas, the cost of serving beneficiaries also varies. For example, our members report that even within Alaska or Hawaii the costs of doing business in one part of the state may be much higher than in another. Alaska is also subject to requirements of the Jones Act, which makes shipping into the state extremely expensive. Our manufacturer members report that it is "drastically more expensive" to ship to Alaska and Hawaii than it is to ship within the lower 48 states.

Regarding Alaska, there appears to be no large national or regional suppliers serving the state. Alaska's 70,000 Medicare beneficiaries are spread over an incredibly large and logistically-difficult area (2.5 times the size of the state of Texas) and are being serviced by a handful of small, independent suppliers.

AAHomecare monitors and analyzes the supplier database that CMS maintains to determine changes in suppliers and physical locations. Our data indicates there has been a 39% reduction in traditional DMEPOS suppliers from July of 2013 to January 2017. AAHomecare analyzes the data to create a subset of suppliers who provide hospital beds, negative pressure wound therapy, wheelchairs (manual and power), wheelchair accessories, oxygen, sleep, RAD, support surfaces and enteral therapy. Those suppliers who only provide walkers, disposable supplies and other specialty type items covered under DMEPOS are not considered 'traditional' suppliers for the purpose of our evaluation. A 39% reduction is very significant as we look at continuing the ability to service Medicare beneficiaries both in and outside of CBAs.

According to one national supplier, it has closed 25 branches in 2016 alone, no longer services North Dakota, Montana, and Alaska and has reduced its geographic coverage in rural Wisconsin, Michigan, Minnesota, Indiana, Kentucky and Virginia. Similarly, a large regional supplier has closed 11 of its original 22 locations in the last two years. Additionally, suppliers have had to cut back on staffing which has resulted in delays in order processing and reduction in value-added services such as off-cycle oxygen deliveries and enhanced access to respiratory therapists.

Supplier members have also reported that on average a delivery costs anywhere from \$74 to \$62 per delivery. One supplier indicated that on average in non-CBAs it has 7 deliveries per day versus 20 per day in CBAs. The reasons cited for the increase in direct costs are: larger geographical footprint

resulting in more miles driven between deliveries and fewer patients in need of DMEPOS to support the expense of staff.

According to an industry member buying group's recent survey, 10% of suppliers indicate a shrinking service area, 15% a reduction in products offered and 18% reduction in the number of suppliers in their geographic area.

While CMS continues to track health metrics, the industry has questioned the comprehensive nature of what is tracked and published quarterly. AAHomecare has often requested that CMS expand the metrics that are evaluated. What about those patients who choose to go without needed equipment and supplies or those that pay cash simply to receive needed items quickly? Has the lag in time to obtain equipment increased thereby forcing hospital systems to absorb some of the equipment costs associated with discharge? Are beneficiaries being discharged without all of the goods and services they need? An analysis of how long it takes between a beneficiary being discharged from the hospital to the date the beneficiary receives a hospital bed would be another way to gauge the timeliness of receipt of medical necessary equipment. In terms of rural markets, a study of those suppliers that provided services according to 2015 claims payment data to 2016 might demonstrate exactly how many and which suppliers are continuing to provide items and services in rural markets. All of these measures should be looked at before CMS continues to roll out flawed pricing to the entire country.

As a participant on the industry stakeholder call, it became very apparent that issues exist outside of CBA areas from Maine to California. The stories told by suppliers and referral sources all had the same theme: the cuts are too severe, suppliers cannot exist on the current regional SPAs, Medicare beneficiaries are not being serviced at the level they need. There was a sense of urging CMS to reconsider what has been done as part of the requirement in the CURES Act.

There is a functioning workgroup within CMS in the Ombudsman's Office focusing on access to care issues in non-CBA areas. AAH has been in conversations with these individuals in attempts to help secure suppliers in non-contiguous areas of the United States. It is clear that there are now areas that are having issues with accessibility. Should the program continue as is, these issues will only increase in the lower 48 states as well.

AAHomecare would like to ask what process CMS will be following the industry call? Will there be a rulemaking process to follow? Will CMS respond to the myriad of issues raised by suppliers and other industry stakeholders?

AAHomecare appreciates the opportunity to submit these comments and reiterates our commitment to working with CMS in order to arrive at a workable payment system for durable medical equipment. We would be happy to meet and discuss these issues in more detail, as well as discuss our detailed recommendations on how CMS can effectively address the deficiencies in the current bidding program. Please feel free to contact me should you have any questions or if I can be of any assistance.

Sincerely,



Kimberley S. Brummett
VP Regulatory Affair