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December 21, 2018

The Honorable Steve Womack
Chairman
Committee on the Budget
House of Representatives

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Fred Upton
House of Representatives

Medicare Fee-For-Service: Information on the Second Year of Nationwide Reduced Payment Rates for Durable Medical Equipment

Medicare helps pay for medically necessary durable medical equipment (DME) items, such as wheelchairs and oxygen.¹ In its fee-for-service (FFS) Part B program, Medicare beneficiaries typically obtain DME items from suppliers, who then submit claims for payment to Medicare on behalf of beneficiaries.²

Historically, Medicare paid for DME items by using a fee schedule generally based on what suppliers charged during the 1980s, and these amounts were updated annually. However, both we and the Department of Health and Human Services’s (HHS) Office of Inspector General reported that Medicare and its beneficiaries sometimes paid higher than market rates for various DME items, and there were long-standing concerns about high improper payment rates related to DME. To achieve savings and address improper payment concerns, Congress—through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—directed the

¹DME items must be prescribed by a physician in order to be covered by Medicare Part B. For this report, the term DME item refers to durable medical equipment, prosthetics, orthotics, and supplies. DME serves a medical purpose, can withstand repeated use, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home, including, for example, wheelchairs and hospital beds. Prosthetic devices (other than dental) are defined as devices needed to replace body parts or functions. Orthotic devices are defined as providing rigid or semi-rigid support for weak or deformed body parts or restricting or eliminating motion in a diseased or injured part of the body.

²Beneficiaries enrolled in Medicare Advantage plans, which are operated by private organizations, obtain DME items through their Medicare Advantage plans.

Centers for Medicare & Medicaid Services (CMS) to implement a competitive bidding program (CBP) in certain geographic areas for certain DME items.³ CMS implemented the CBP in 2011, and it is currently operating in 130 designated U.S. areas.⁴

The Patient Protection and Affordable Care Act required CMS to use information from the CBP to adjust FFS payment rates (hereafter referred to as adjusted rates) for certain DME in all areas that are not included in the CBP (hereafter referred to as non-bid areas).⁵ Starting on January 1, 2016, CMS used payment information from the CBP to adjust FFS payment rates for 393 DME items in non-bid areas (hereafter referred to as rate-adjusted items).⁶ CMS estimates these adjustments in non-bid areas will save the Medicare program about \$3.6 billion and beneficiaries about \$1.2 billion between fiscal years 2016 and 2020.

We issued a report in July 2018 that reviewed the effects of adjusted rates in non-bid areas based on Medicare claims data for 2016—the first year adjusted rates were in effect and the most recent year of complete data available at the time of our study.⁷ We found the number of suppliers who furnished rate-adjusted items in non-bid areas decreased during the first year (continuing a long-term trend that began before CMS adjusted rates in non-bid areas), and beneficiary utilization showed little change. We also found little difference between non-rural and rural non-bid areas in terms of supplier and beneficiary utilization changes.⁸

³Pub. L. No. 108-173, § 302(b), 117 Stat. 2066, 2224-30 (2003) (codified, as amended, at 42 U.S.C. § 1395w-3). The CBP applies to DME items furnished to Medicare FFS Part B program beneficiaries. It does not apply to beneficiaries enrolled in Medicare Advantage plans.

⁴In CBP areas, generally only suppliers who are awarded a contract can furnish certain DME items at competitively determined prices to Medicare beneficiaries residing in CBP areas, and they are contractually obligated to furnish items in their contract upon request. Current CBP contracts expire on December 31, 2018. However, on November 1, 2018, CMS announced that the agency had not yet started the process to recompetete contracts and that there will be a temporary gap period in the CBP that CMS officials expect will last until December 31, 2020. According to the announcement, during the temporary gap period, beneficiaries in CBP areas may receive DME items from any willing Medicare-enrolled supplier. According to a final rule, during the temporary gap period, CMS will pay suppliers an adjusted FFS rate calculated in part based on the rate in effect in the CBP area on the last day of the CBP contract. See 83 Fed. Reg. 56,922 (Nov. 14, 2018).

⁵Pub. L. No. 111-148, § 6410, 124 Stat. 119, 773 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). We defined non-bid areas as any zip codes in the 50 U.S. states and the District of Columbia that were not included in CMS's list of CBP area zip codes for CBP rounds in effect at the end of 2016.

⁶According to CMS, it initially used a phased-in approach to adjust FFS payment rates beginning in 2016. From January 1 through June 30 of 2016, FFS payment rates were based on a 50/50 blend of non-adjusted and adjusted rates, and from July 1 through December 31 of the same year, FFS payment rates were 100 percent adjusted based on CBP information. However, the 21st Century Cures Act required CMS to retroactively apply the 50/50 blended payment rates to claims in the second half of 2016, delaying the fully adjusted rates to January 1, 2017. Pub. L. No. 114-255, § 16007, 130 Stat. 1033, 1328 (2016). Fully, 100 percent adjusted rates were in effect for all of 2017 and the first five months of 2018 in all non-bid areas. In May 2018, CMS issued an interim final rule with comment period to resume higher 50/50 blended rates for rate-adjusted items furnished in rural contiguous and all non-contiguous non-bid areas only from June 1, 2018, through December 31, 2018. 83 Fed. Reg. 21,912 (May 11, 2018).

⁷GAO, *Medicare Fee-For-Service: Information on the First Year of Nationwide Reduced Payment Rates for Durable Medical Equipment*, [GAO-18-534](#) (Washington, D.C.: July 25, 2018).

⁸We also found reductions in payment rates were generally substantial but varied by category of DME item, and that CMS's activities to monitor beneficiary access, including changes in health outcomes, showed little change between 2015 and 2016.

After we published that report, Medicare claims data became available for 2017, the second year adjusted rates were in effect. You asked us to update our analysis of supplier and utilization changes with the 2017 Medicare claims data. To do that, we examined

- (1) changes in the number of suppliers furnishing rate-adjusted versus non-adjusted items to beneficiaries in non-bid areas; and
- (2) changes in the number of Medicare beneficiaries receiving rate-adjusted versus non-adjusted items in non-bid areas.

We used the same methodology we used for our July 2018 report. Specifically, we used Medicare claims data and other CMS data to calculate percentage changes in the number of suppliers furnishing any of the 393 rate-adjusted items to Medicare beneficiaries in non-bid areas from 2010 through 2017. A supplier had to submit at least one claim for a DME item with an allowed charge greater than zero each year to be included in the analysis. We used these same data to calculate percentage changes in the number of Medicare beneficiaries in non-bid areas who utilized at least one rate-adjusted item each respective year from 2010 through 2017.⁹ The figures in this report follow the format of those in our July 2018 report with the addition of information for 2017.

We assessed the reliability of the Medicare claims data and other CMS data we used for this report by reviewing existing information about the data and the systems that produced them, performing electronic data checks, and interviewing CMS officials. On the basis of these steps, we determined that these data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from July 2018 to December 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

During 2017, the second year CMS adjusted rates in non-bid areas, the number of suppliers furnishing rate-adjusted items in non-bid areas decreased 11 percent. This continued a trend of annual decreases going back to at least 2011. Beneficiary utilization of rate-adjusted items in non-bid areas in 2017 decreased 2 percent compared to 2016. This followed a decrease of less than half of 1 percent between 2015 and 2016.

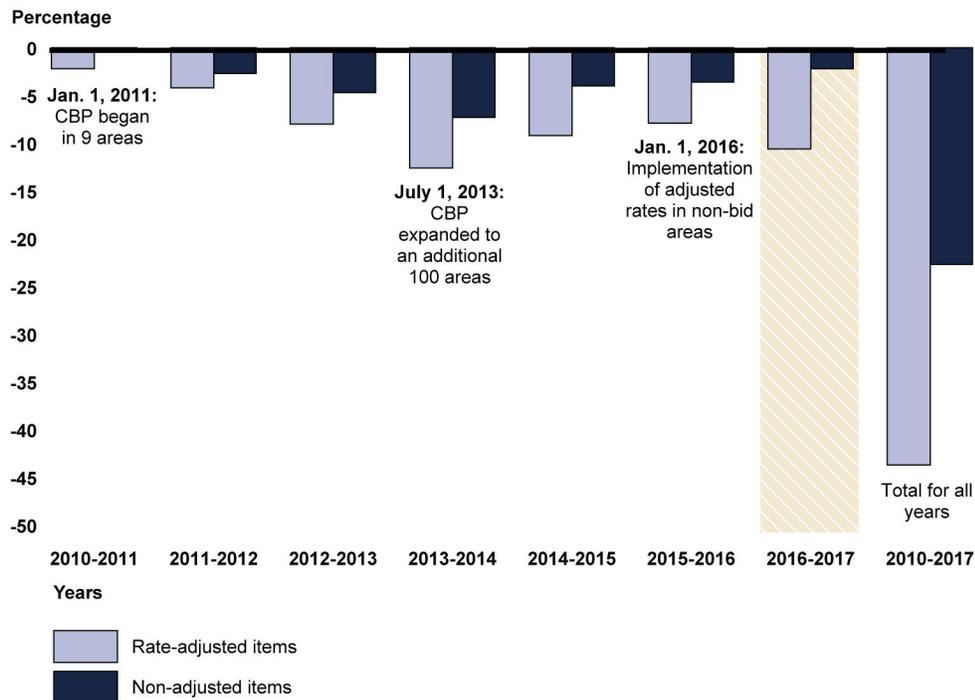
In 2017, Number of Suppliers Furnishing Rate-Adjusted Items in Non-Bid Areas Continued to Decrease

In the second year that CMS adjusted rates in non-bid areas, the number of suppliers furnishing rate-adjusted items to beneficiaries decreased overall and in all product categories. Specifically:

⁹See [GAO-18-534](#) for a detailed description of our methodology. We define “beneficiary utilization” as the number of beneficiaries associated with a paid claim for a rate-adjusted or non-adjusted item. A decrease in the number of beneficiaries associated with a paid claim does not necessarily equate to a drop in access or change in volume of furnished, medically necessary items.

- The number of suppliers furnishing rate-adjusted items to beneficiaries in non-bid areas in 2017—the second year that CMS adjusted rates in non-bid areas—decreased 11 percent compared to 2016. This followed an 8 percent decrease in 2016 compared to 2015 and continued a trend of annual decreases that averaged 8 percent per year in non-bid areas going back to at least 2011.
 - The number of suppliers furnishing non-adjusted items to beneficiaries residing in non-bid areas decreased 2 percent in 2017 compared to 2016. This followed a 4 percent decrease in 2016 compared to 2015.
- (See fig. 1.)

Figure 1: Year-to-Year Percentage Decrease in the Number of Suppliers Furnishing Rate-Adjusted versus Non-Adjusted Items to Medicare Beneficiaries in Non-Bid Areas, 2010–2017

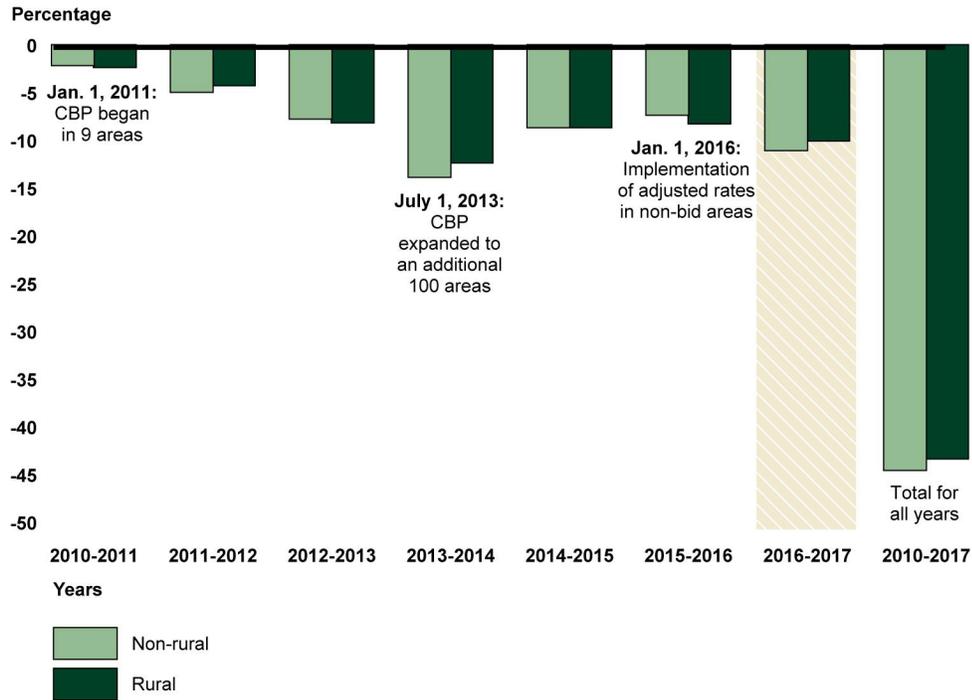


Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). Non-adjusted items refer to DME items not included in the CBP. Each supplier was identified by its tax identification number and submitted at least one claim for a DME item with an allowed charge greater than zero each year. This analysis is limited to items furnished to Medicare beneficiaries residing in the 50 U.S. states and the District of Columbia. A missing bar for a given year indicates a percentage too small to chart. We highlighted the 2016-2017 bars in the figure because 2017 is the second year that CMS adjusted rates in non-bid areas, which is the focus of this report.

- There was little difference between non-rural and rural non-bid areas in terms of percentage decreases in the number of suppliers furnishing rate-adjusted items to beneficiaries between 2016 and 2017. This has been the case going back to at least 2011. (See fig. 2.)

Figure 2: Year-to-Year Percentage Decrease in the Number of Suppliers Furnishing Rate-Adjusted Items to Medicare Beneficiaries in Non-Bid Areas, by Non-Rural versus Rural Areas, 2010–2017

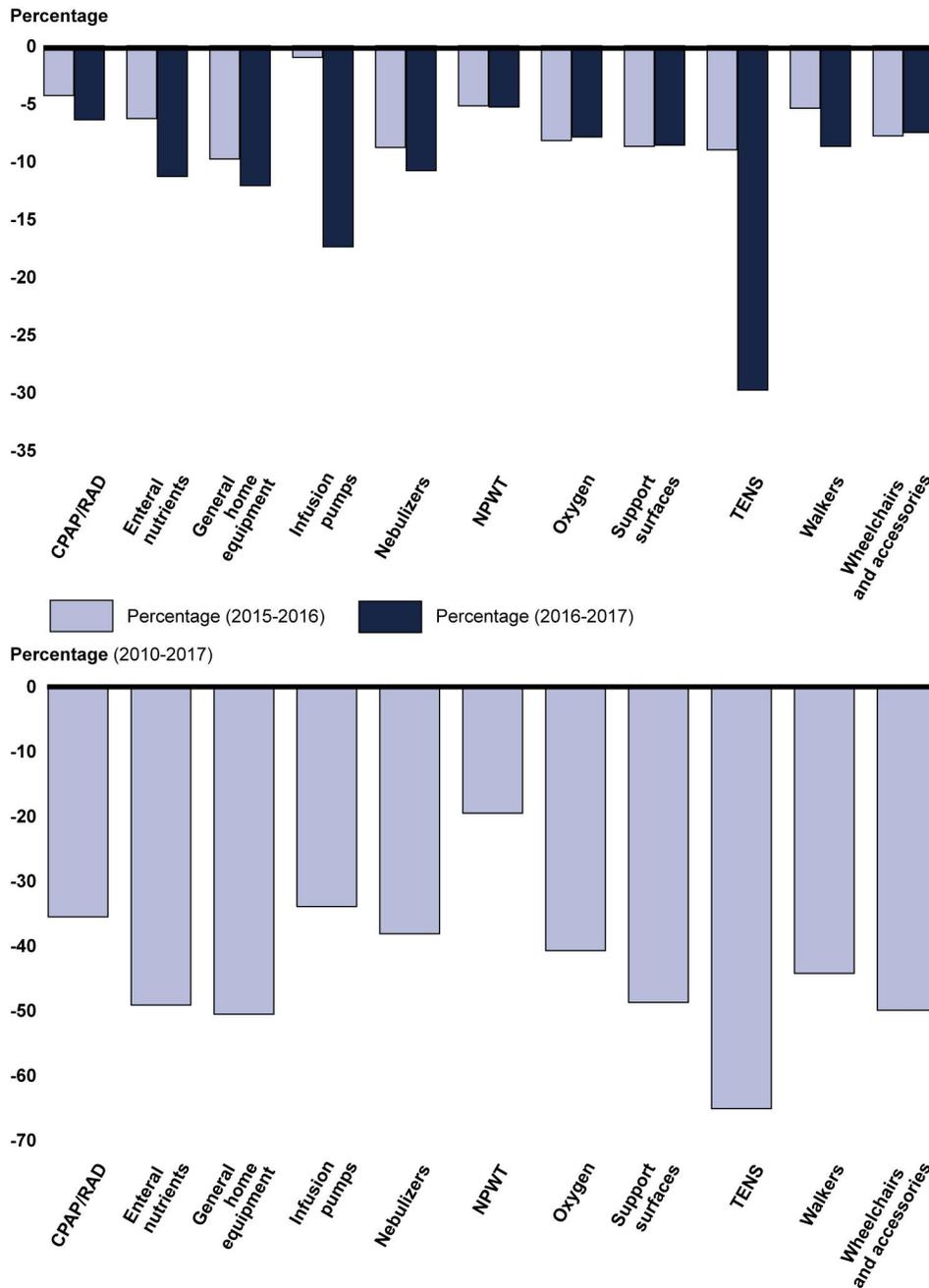


Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). Each supplier was identified by its tax identification number and submitted at least one claim for a DME item with an allowed charge greater than zero each year. This analysis includes suppliers who furnished rate-adjusted items to Medicare beneficiaries in non-bid areas in the 50 U.S. states and the District of Columbia. Non-bid areas in Alaska and Hawaii are categorized as non-rural because CMS does not distinguish between rural and non-rural areas for purposes of adjusted rates. We highlighted the 2016-2017 bars in the figure because 2017 is the second year that CMS adjusted rates in non-bid areas, which is the focus of this report.

- The number of suppliers furnishing rate-adjusted items in non-bid areas decreased between 2016 and 2017 in all product categories, though the extent of these decreases varied. The decreases between 2016 and 2017 were larger or about the same as the decreases between 2015 and 2016. (See fig. 3.)

Figure 3: Percentage Decrease in the Number of Suppliers Furnishing Rate-Adjusted Items to Medicare Beneficiaries in Non-Bid Areas, by Product Category, 2015–2016, 2016–2017, and 2010–2017^a



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service (FFS) payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). Each supplier was identified by its tax identification number and submitted at least one claim for a DME item with an allowed charge greater than zero each year. This analysis includes suppliers who furnished rate-adjusted items to Medicare beneficiaries in non-bid areas in the 50 U.S. states and the District of Columbia. CPAP/RAD refers to continuous positive airway pressure devices and respiratory assist devices; NPWT refers to negative pressure wound therapy; and TENS refers to transcutaneous electrical nerve stimulation. According to CMS, the relatively large decrease in the number of suppliers furnishing infusion pumps between 2016 and 2017 reflects a CMS policy clarification that certain charges related to services provided by a physician’s office or hospital outpatient department should not be billed as a DME claim. CMS officials also told us that the decrease in

the number of suppliers furnishing TENS between 2016 and 2017 was largely due to Medicare no longer covering the use of TENS for lower back pain and may also be due to the availability of relatively inexpensive over-the-counter devices.

^aCMS began implementing the CBP on January 1, 2011, in nine areas and expanded the CBP to an additional 100 areas on July 1, 2013. CMS began implementing adjusted FFS payment rates in non-bid areas on January 1, 2016.

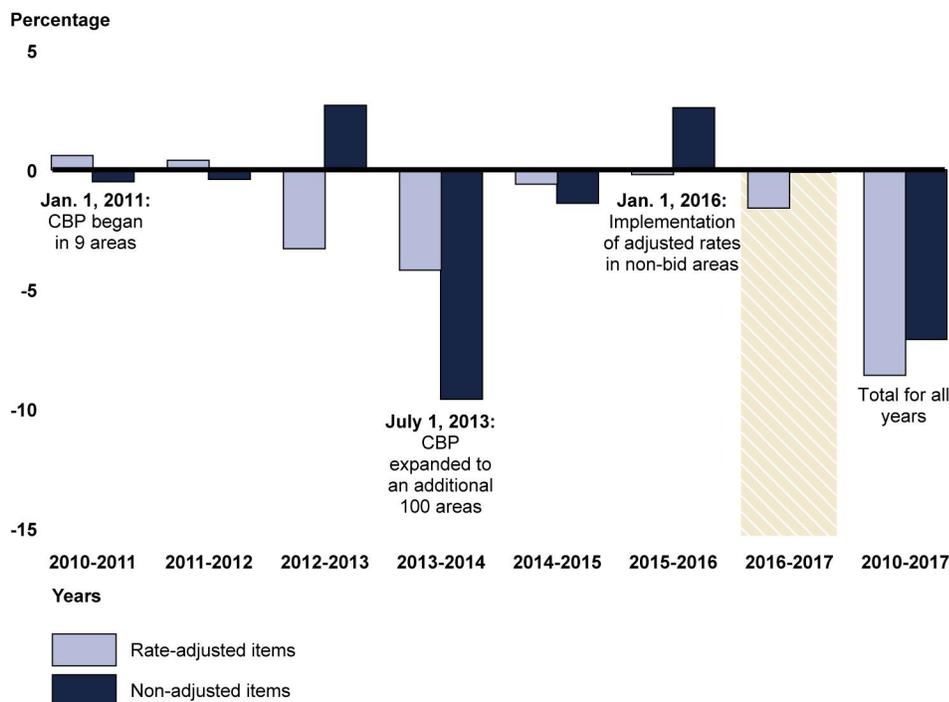
Beneficiary Utilization of Rate-Adjusted Items Decreased Slightly in 2017

In the second year that CMS adjusted rates in non-bid areas, the number of beneficiaries receiving rate-adjusted items decreased overall and in most product categories. Specifically:

- The number of beneficiaries in non-bid areas receiving at least one rate-adjusted item in 2017 decreased 2 percent compared to 2016. This followed a decrease of less than half of 1 percent between 2015 and 2016.
- The number of beneficiaries in non-bid areas who received at least one non-adjusted item showed little change in 2017 compared to 2016 (a decrease of less than half of 1 percent). This followed an increase of 3 percent in 2016 compared to 2015.

(See fig. 4.)

Figure 4: Year-to-Year Percentage Change in the Number of Medicare Beneficiaries Receiving Rate-Adjusted versus Non-Adjusted Items in Non-Bid Areas, 2010–2017



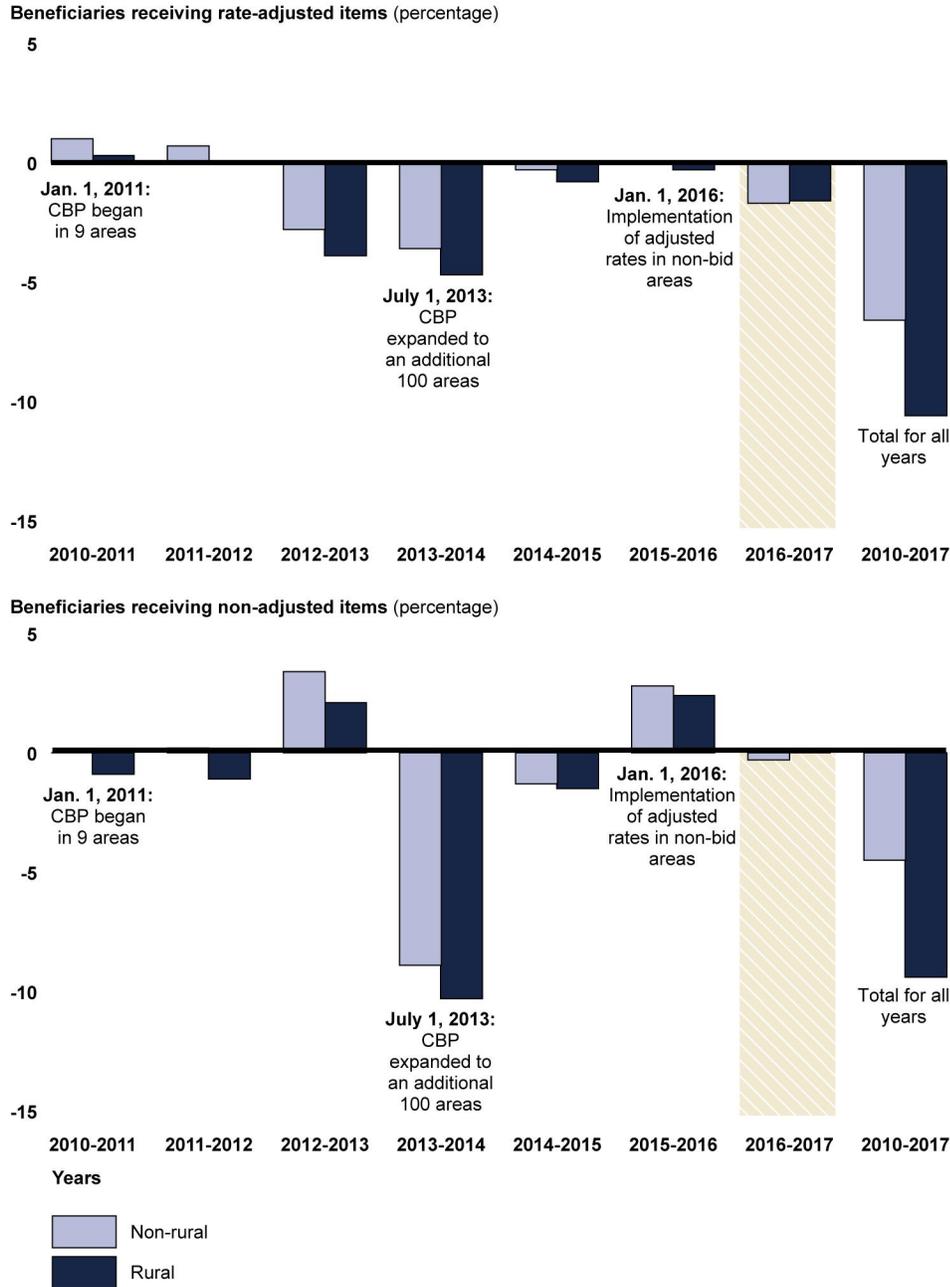
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). Non-adjusted items refer to DME items not included in the CBP. This analysis includes Medicare beneficiaries residing in the 50 U.S. states and the District of Columbia who received at least one DME item of the respective type. A missing bar for a given year indicates a percentage too small to chart. We highlighted the 2016-2017 bars in the figure because 2017 is the second year that CMS adjusted rates in non-bid areas, which is the focus of this report.

- There was little difference between non-rural and rural non-bid areas in terms of percentage changes in the number of beneficiaries who received rate-adjusted items

between 2016 and 2017. There was also little difference in terms of the percentage changes in the number of beneficiaries who received non-adjusted items. (See fig. 5.)

Figure 5: Year-to-Year Percentage Change in the Number of Medicare Beneficiaries Receiving Rate-Adjusted versus Non-Adjusted Items in Non-Rural versus Rural Non-Bid Areas, 2010–2017

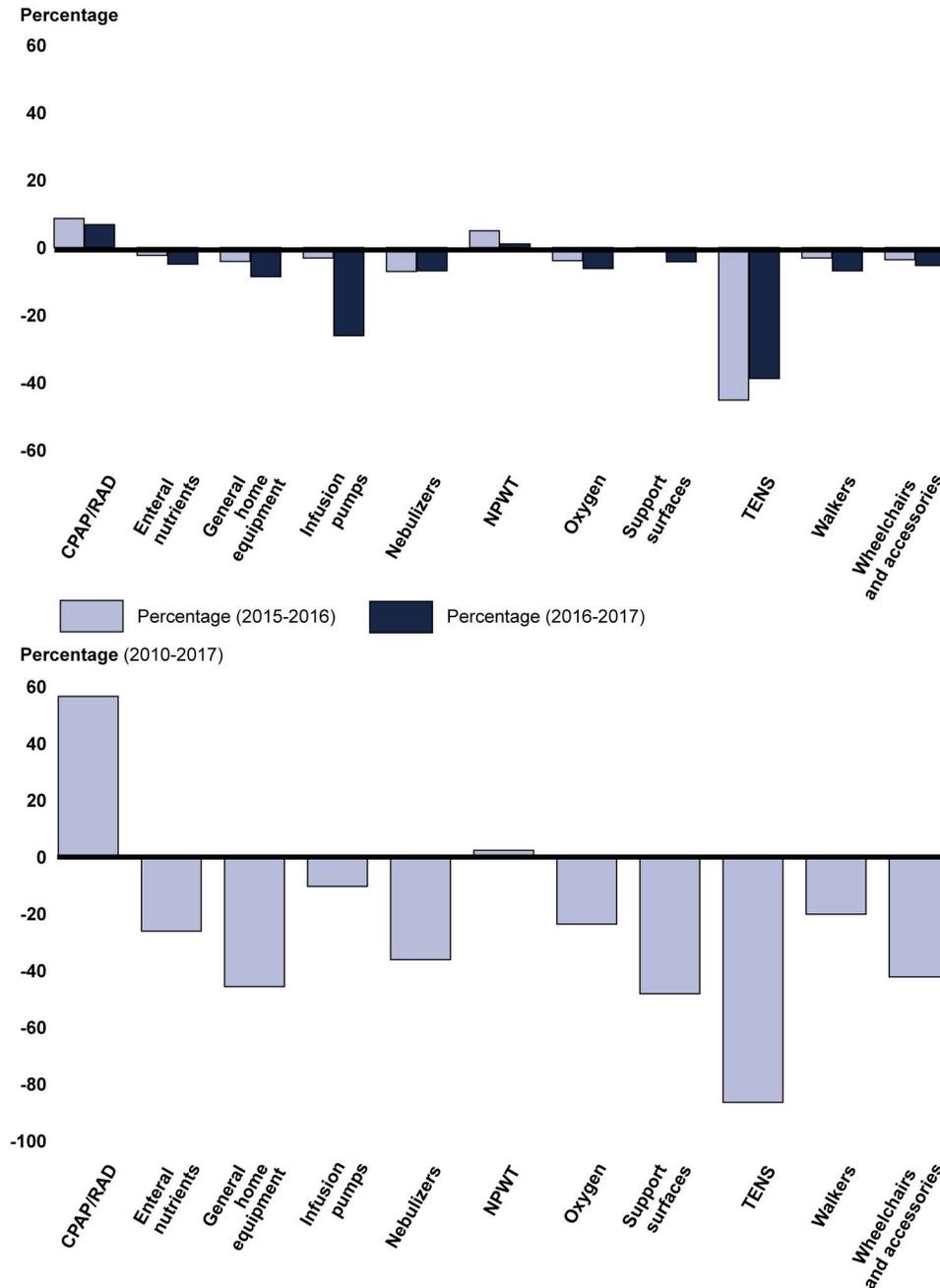


Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). Non-adjusted items refer to DME items not included in the CBP. This analysis includes Medicare beneficiaries residing in the 50 U.S. states and the District of Columbia who received at least one DME item of the respective type. Non-bid areas in Alaska and Hawaii are categorized as non-rural because CMS does not distinguish between rural and non-rural areas for purposes of adjusted rates. A missing bar for a given year indicates a percentage too small to chart. We highlighted the 2016-2017 bars in the figure because 2017 is the second year that CMS adjusted rates in non-bid areas, which is the focus of this report.

- The number of beneficiaries in non-bid areas receiving at least one rate-adjusted item in 2017 decreased for 9 of the 11 product categories, and the extent of these decreases varied. (See fig. 6.)

Figure 6: Percentage Change in the Number of Medicare Beneficiaries Receiving Rate-Adjusted Items in Non-Bid Areas, by Product Category, 2015–2016, 2016–2017, and 2010–2017^a



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-19-153R

Notes: Rate-adjusted items refer to durable medical equipment (DME) items with fee-for-service payment rate adjustments made by the Centers for Medicare & Medicaid Services (CMS) based on information from the competitive bidding program (CBP). This analysis includes Medicare beneficiaries residing in the 50 U.S. states and the District of Columbia who received at least one DME item of the respective type. CPAP/RAD refers to continuous positive airway pressure devices and respiratory assist devices; NPWT refers to negative pressure wound therapy;

and TENS refers to transcutaneous electrical nerve stimulation. According to CMS, the relatively large decrease in the number of beneficiaries receiving infusion pumps between 2016 and 2017 reflects a CMS policy clarification that certain charges related to services provided by a physician's office or hospital outpatient department should not be billed as a DME claim. CMS officials also told us that the decrease in the number of beneficiaries receiving TENS between 2015 and 2016 was due in part to a single supplier exiting the market who was strongly suspected for improperly supplying TENS to beneficiaries. Other factors that contributed to the decrease in use of TENS include Medicare no longer covering the use of TENS for lower back pain and the availability of relatively inexpensive over-the-counter devices. A missing bar for a given year indicates a percentage too small to chart.

^aCMS began implementing the CBP on January 1, 2011, in nine areas and expanded the CBP to an additional 100 areas on July 1, 2013. CMS began implementing adjusted fee-for-service payment rates in non-bid areas on January 1, 2016.

Agency Comments

We provided a draft of this report to HHS for comment. HHS provided technical comments, which were incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and appropriate congressional committees. The report will also be available at no charge on our website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other key contributors to this report were Martin T. Gahart, Assistant Director; Barbara Hansen, Analyst-in-Charge; Sam Amrhein; Todd Anderson; Michelle Paluga; and Emily Wilson.



James Cosgrove
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