United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

April 18, 2016

The Honorable Sylvia M. Burwell
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

We are writing to urge the Centers for Medicare & Medicaid Services (CMS) to extend the current six-month phase-in of the modified fee schedule for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for an additional 12 months to avoid disruption in care to beneficiaries, especially in rural areas. We are concerned that the current six-month phase-in is insufficient to assess the impact of the first half of the rate reduction that took effect on January 1, 2016. As the second half of the rate reduction is to take effect on July 1, 2016, we also ask that the agency announce the extension as soon as possible. In addition, we urge CMS to share the specific indicators the agency is monitoring to determine if beneficiaries experience access problems or adverse outcomes and to report the results publicly on the agency's website.

Specifically, we are concerned that the current six-month period does not allow sufficient time to detect and correct problems and, as a result, puts beneficiaries at risk of experiencing a delay in the receipt of needed DMEPOS or being unable to obtain items altogether. It is unlikely that CMS will be able to monitor, analyze, and make any necessary changes prior to July 1, 2016. The ability of the real-time claims monitoring that CMS uses for items provided in competitive bidding areas to assess the short-term impact of the DMEPOS fee schedule rate reduction in non-competitive bidding areas is questionable. The impact of adjusted fee schedule prices would seem to require a comparison of indicators in each geographic area against its own prior benchmark. However, it is unclear the extent to which claims data will be complete at any point during the six month phase-in period, considering that suppliers have 12 months to submit their claims from the date of service. Accordingly, there is limited ability to assess the impact of the first half of the rate reduction on indicators such as deaths, hospitalizations, hospital length of stay, emergency room visits, and nursing facility admissions.

While we appreciate that CMS is monitoring to assess the impact of initial, January 1, 2016 rate reduction on beneficiaries, we believe it is important for the agency to share the specifics of its monitoring plan with Congress and all stakeholders. CMS stated its intent to monitor in the DMEPOS fee schedule adjustment final rule published in 2014; however, since then, the agency has not publicly articulated the specifics of its monitoring plan. We urge CMS not only to make the indicators it is using to monitor publicly available as soon as possible, but also to update the

monitoring results on a regular basis and provide sufficient detail to show the specific impact on rural areas.

One valuable indicator currently available to CMS is the percentage of DMEPOS claims that suppliers have submitted as "assigned," meaning that they agree to accept the Medicare fee schedule allowed amount as payment in full. We ask that CMS provide the assigned claims percentage for each month in 2016 as it compares to 2015, both overall and by each non-competitive bidding geographic area. An increase in non-assigned claims means beneficiaries are paying more out of pocket, as non-assigned suppliers can charge above the Medicare fee schedule allowed amount without limit. An increase in items furnished by non-assigned suppliers would effectively shift costs from the Medicare program to beneficiaries. It would also be helpful to know the number of beneficiary complaints in the non-competitive bidding areas received by CMS since January 1, 2016. We ask that CMS provide this information and, for purposes of this request, define complaint broadly so that it is not limited to those complaints unable to be resolved by the initial customer service point of contact.

In addition, CMS has demonstrated that it has the discretion in implementing the statutory requirement to adjust the DMEPOS fee schedule based on competitive bidding prices by establishing a six-month phase-in. Further, CMS Acting Administrator Slavitt stated that the agency has broad authority while testifying at a January 21, 2016 Senate Finance Committee hearing. Thus, we see no barrier to the agency establishing a longer transition.

We appreciate that CMS has a responsibility to implement the statute and the agency's intent to reduce Medicare expenditures, but believe caution is necessary to ensure that beneficiaries have access to needed DMEPOS in non-bidding areas. We therefore request that CMS evaluate the impact of the initial reduction over a longer period of time and provide the specifics of its monitoring plan and the results to Congress and all stakeholders.

Sincerely,

Orrin Hatch
Chairman

Ron Wyden
Ranking Member

Cc: Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services