FY 2021 President's Budget Proposals—DME Industry

Source: https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf

1. Reform and Expand Durable Medical Equipment Competitive Bidding

Under the Medicare Durable Medical Equipment (DME) Competitive Bidding Program, DME suppliers can submit low bids during the competition to win a Medicare contract and get paid a higher price even though their low bid reduced prices for all other suppliers in the competition area. CMS must use prices from urban DME competitions to inform fee schedule prices in rural areas, thereby undervaluing true costs in rural areas and threatening access to care. Effective CY 2024, this proposal changes the way Medicare pays for DME under the competitive bidding program, from a single payment amount based on the maximum winning bid to each winning suppliers' own bid amounts. As a result, Medicare payment to low bidders will equal their low bid amount. It also expands competitive bidding to additional geographic areas, including rural areas, and includes inhalation drugs as a service category for the first time. To reduce burden on suppliers, this proposal also removes the surety bid bond, which requires all suppliers to secure a surety bond for every competition. In the event that fewer than two suppliers submit bids in a rural area, CMS will base prices on information from similar rural areas. Expanding competitive bidding will allow CMS to base prices for DME items and services in rural areas on competitions in those areas rather than setting fee schedule prices in rural areas based on competitions in urban areas. [$7,730 billion in Medicare savings and $435 million in Medicaid savings over 10 years]

2. Use Retail Price Information for Durable Medical Equipment Fee Schedule Rates

Medicare often pays much higher rates for DME than the retail price for these items in the open market. To update the DME fee schedule based on retail price information, CMS must conduct a complex and onerous inherent reasonableness process, making it administratively burdensome for CMS to update DME prices even as the market or technology changes. This proposal allows CMS to annually update DME prices based on retail prices through rulemaking, without using the inherent reasonableness process. This change will allow Medicare prices to adapt to rapidly changing and often cheaper technology, and reduce Medicare costs as DME prices drop in the retail market. [$1.6 billion in Medicare savings and $85 million in Medicaid savings over 10 years]

3. Eliminate the Unnecessary Requirement of a Face-to-Face

Provider Visit for Durable Medical Equipment Physicians must document a beneficiary's face-to-face encounter with a physician or a non-physician practitioner as a condition for Medicare payment for a DME order. This proposal allows CMS flexibility in the enforcement of the face-to-face requirement, eliminating this overly burdensome requirement for most Medicare providers and beneficiaries. [Budget Neutral]

4. Support Coverage for Innovative Alternatives to Durable Medical Equipment for Treatment and Management of Diabetes

Medicare DME coverage excludes non-durable alternatives to DME. This proposal allows Medicare coverage for innovative non-durable medical equipment alternatives to treat and manage diabetes.

Payment for these alternative items would be subject to competitive bidding and capped at the payment rate for their DME counterpart. Allowing access to these alternatives makes it possible for beneficiaries to choose items and services that better suit their medical needs. [Budget Neutral]

5. Address Excessive Billing for Durable Medical Equipment that Require Refills on Serial Claims

In FY 2019, almost 31 percent of Medicare payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies were improper. By leveraging Medicare demonstration authority, this proposal tests whether using a benefits manager for serial durable medical equipment claims results in lower improper payments and reductions in inappropriate utilization. The benefits manager would be responsible for ensuring beneficiaries were receiving the correct quantity of supplies or services for the appropriate period. [Budget Neutral]

6. **Expand Prior Authorization to Additional Medicare Fee-for-Service Items at High Risk of Fraud, Waste, and Abuse**

Prior authorization can be an effective tool for healthcare payers to support payment accuracy and reduce unnecessary utilization, but current law allows Medicare to use this tool on only a few fee-for-service items and services. This proposal extends the narrow existing authority to all Medicare Fee-for-Service items and services, and CMS will target this authority toward items and services that are at high risk for fraud and abuse, such as inpatient rehabilitation facilities. By allowing prior authorization on additional items and services, CMS can reduce Medicare improper payments. [$13.7 billion in savings over 10 years] Assess a Penalty on Physicians and Practitioners who Order Services or Supplies without Proper Documentation Under current law, Medicare cannot hold a practitioner financially accountable for improperly documenting ordered items or services. This proposal allows the Secretary to assess an administrative penalty on practitioners for ordering high-risk, high-cost items or services without proper documentation, such as diagnosis or encounter data. The penalty would be $50 for Part B items/services and $100 for Part A services. [Budget Neutral]

7. **Reduce Utilization of Low-Value Health Services through Prior Authorization Demonstrations**

Medicare low-value health services currently pose risks of over-utilization or provision of care that is unlikely to improve health and can potentially harm patients. CMS will explore options within their current authority to test if applying prior authorization on low-value services can reduce Medicare costs by reducing unnecessary utilization. When implementing this proposal, CMS will consider patient access and other quality concerns, in an effort to reduce patient burden while ensuring appropriate provisions of healthcare. [Budget Neutral]

8. Change the Medicare Appeal Council's Standard of Review

Currently, when a party files a request for review of an Administrative Law Judge decision, the Departmental Appeals Board’s Medicare Appeal Council must review the decision de novo, from the beginning. This proposal changes the Council’s standard of review from a de novo to an appellate-level standard of review. Changing the Departmental Appeals Board’s standard of review will increase adjudication capacity by up to 30 percent and further distinguish the Council’s role as an administrative appellate body. [Budget Neutral]

9. Establish a Post-Adjudication User Fee for Level 3 and Level 4 Unfavorable Medicare Appeals

Currently, there are no administrative fees charged for filing a Medicare appeal, which has in some cases resulted in appellant's filing non-meritorious appeals. This proposal establishes a post-adjudication user fee for all Medicare appeals, other than beneficiary appeals, which are denied, or otherwise receive unfavorable disposition, by the Office of Medicare Hearings and Appeals and the Departmental Appeals Board. The user fee supports 10 percent of the administrative costs required to adjudicate appeals and encourage those appellants who frequently file to more carefully assess their appeals before filing. [User fee revenue of $20.4 million over 10 years]

10. Expedite Procedures for Claims with No Material Fact in Dispute

Appellants have an option to bypass the Administrative Law Judge (ALJ) hearing at the third level of Medicare appeals by requesting expedited access to judicial review if specific conditions are met. This proposal allows the Office of Medicare Hearings and Appeals to issue decisions on the record without holding a hearing if there is no material fact in dispute. These cases include appeals, for example, in which Medicare does not cover the cost of a particular drug or the ALJ cannot find in favor of an appellant due to binding limits on authority. This proposal increases the efficiency of the Medicare appeals system and results in faster adjudications of pending appeals at the ALJ level of appeal. [Budget Neutral]

11. Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review

The Social Security Act requires a hearing by an Administrative Law Judge for a Medicare appeal even in situations where the amount-in-controversy is below the cost of adjudicating the claim. This proposal increases the minimum amount in controversy required for adjudication of an appeal by an Administrative Law Judge to the Federal District Court amount in controversy requirement, which is $1,670 in calendar year 2020 and updated annually. This adjustment will allow the amount at issue to better align with the amount spent to adjudicate the claim. Appeals not reaching the minimum amount in controversy will be adjudicated by a Medicare magistrate. [Budget Neutral]

12. Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold

The Social Security Act requires a hearing by an Administrative Law Judge for a Medicare appeal even in situations where the amount-in-controversy is below the cost of adjudicating the claim. This proposal allows the Office of Medicare Hearings and Appeals to use Medicare magistrates for appealed claims below the Federal District Court amount in controversy threshold, which is $1,670 in calendar year 2020 and updated annually. This policy enables Administrative Law Judges to focus on more complex and higher amount in controversy appeals, while ensuring that all appealed claims are adjudicated. [Budget Neutral]

13. Limit Appeals When No Documentation is Submitted

Currently, appellants may pursue Medicare appeals when they have not submitted any documentation. This proposal limits the right for non-beneficiary appellants to appeal a redetermination of a claim denied because no documentation was submitted to support the items or services billed. This proposal

does not apply to beneficiary appeals. Limiting the right to appeal when appellants do not submit documentation will incentivize providers and suppliers to submit documentation at the beginning of the appeals process so decisions can be made at the lowest, least costly level of appeal. [Budget Neutral]

14. Remand Appeals to the Redetermination Level with the Introduction of New Evidence

Currently, a party can submit new evidence at the second level of appeals or later in the administrative appeals process, decreasing the efficiency of the Medicare appeals system and contributing to the backlog of pending appeals at the third and fourth levels of appeal. This proposal permits the remand of an appeal to the first level of appeal when new documentary evidence is submitted into the administrative record at the second or later level of appeal. The proposal permits exceptions if evidence was provided to the lower level adjudicator but erroneously omitted from the record, or if an adjudicator denies an appeal on a new and different basis than earlier determinations. This proposal incentivizes appellants to include all evidence early in the appeals process and ensures the same record is reviewed and considered at subsequent levels of appeal. [Budget Neutral]

15. Require a Good-Faith Attestation on All Appeals

Currently, there are no statutory requirements that appellants consider the merits of their appeal before filing. This proposal requires all appellants to include in their initial appeal filing an attestation that they are submitting their appeal under a good-faith belief that they are entitled to receive Medicare reimbursement. This proposal also authorizes the Secretary to sanction or impose civil monetary penalties on appellants who submit attestations that are found to be unreasonable or made in bad faith. Requiring appellants to provide a good-faith attestation will reduce non-meritorious appeals and indiscriminate filing of appeals by high volume appellants. [Budget Neutral]