



July 9, 2018

SUBMITTED ELECTRONICALLY

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas: (CMS-1687-IFC) Medicare Program

Dear Administrator Verma:

The undersigned members of the Steering Committee of the Independence through Enhancement of Medicare and Medicaid (“ITEM”) Coalition appreciate the opportunity to comment on the above-referenced interim final [rule](#) (the “IFR”). We write to express our comments and concerns with the IFR regarding continued access to quality care for those needing durable medical equipment (DME) in rural and non-contiguous competitive bidding (CB) areas.

The ITEM Coalition is a national consumer and clinician-led coalition advocating for access to and coverage of assistive devices and technologies for persons with injuries, illnesses, disabilities and chronic conditions of all ages. Our members represent individuals with a wide range of disabling conditions, as well as the providers who serve them, including such conditions as multiple sclerosis, paralysis, hearing and speech impairments, cerebral palsy, visual impairments, spinal cord injuries, brain injury, stroke, spina bifida, myositis, limb loss, Osteogenesis Imperfecta (OI), and other life-altering conditions.

Overall, the resumption of the transition period for the phase-in of fee schedule adjustments for non-competitive bidding areas has the potential to improve access for beneficiaries, improve choice for beneficiaries, and maintain the quality of durable medical equipment for beneficiaries. For that, we thank CMS for recognizing the negative impact of the full fee schedule adjustment on beneficiaries in rural and non-contiguous CB areas, and taking proactive steps to ameliorate this impact.

I. Resumption of the Transition Period for the Phase-in of Fee Schedule Adjustments

This IFR resumes the fee schedule adjustment transition period in rural areas and non-contiguous CB areas effective June 1, 2018, in light of concerns regarding the negative consequences of the full fee schedule adjustments in rural and non-contiguous CB areas. The 50/50 blended fee schedule rates will apply in rural and non-contiguous CB areas from June 1, 2018 through December 31, 2018. As outlined below, the ITEM Coalition is very supportive of the resumption of the transition period for the phase-in of fee schedule adjustments because of the impact on access, quality, and choice of durable medical equipment for Medicare beneficiaries. As noted below, we urge CMS to increase the length of the transition period until there is data that demonstrates that an end to the transition period will not decrease access to and choice of quality durable medical equipment for Medicare beneficiaries.

II. Impact on Beneficiaries' Access to Quality Durable Medical Equipment and Choice

Over the past several years, CMS has made significant policy and regulatory changes to the Medicare DME benefit. Many of these changes have been intended to save taxpayer money; however, many ITEM Coalition members report substantial negative effects on beneficiary access to vital DME items and services that improve health and function. This IFR would actually promote beneficiary access to and choice of quality DME for the time it remains in effect.

Access and Choice

There are fundamental differences in providing DME in urban/suburban areas compared to rural areas, differences that add cost to the provision of DME to Medicare beneficiaries. Medicare beneficiaries in rural areas are geographically dispersed, harder to reach, and do not have the same access to systems of care available in more populated areas. Tough terrain, long distances between patients and providers/suppliers, and fewer health care resources mean that DME suppliers must incur added costs to deliver the right medical equipment and supplies to patients on a timely basis. Rural DME suppliers, quite literally, have to go the extra mile for their Medicare patients. This translates into added costs for transportation, delivery and clinical staff, fuel, and other expenses.

With the introduction of competitively bid fees in rural areas, suppliers are being forced to shut down because they could not afford to provide DME to patients in rural areas. This exacerbates the problem of already-low numbers of DME suppliers in rural and non-contiguous areas, which creates an access problem for rural Medicare beneficiaries. Medicare beneficiaries have experienced interruptions in continuity of care and barriers to DME access as a result of this flawed approach to reimbursement for DME in rural areas. The resumption of the blended rates promotes access for beneficiaries in rural areas, as it will be less likely suppliers will be forced to close or stop providing DME to Medicare beneficiaries. The blended rates also help to provide choices to beneficiaries to select from among a greater number of DME suppliers, as well as a greater variety of brand name items and services.

Quality

Facing increased challenges of operating in rural areas, suppliers have to cut costs elsewhere to make ends meet. This means limiting the range of DME provided to beneficiaries to less expensive, often lower quality, DME, reducing staff, making home deliveries less often, and other methods of reducing supplier cost. All of these cost saving measures compromises the quality of the existing Medicare DME benefit. This IFR will increase the likelihood that beneficiaries will receive quality DME, as rural suppliers will be properly reimbursed for the costs of providing DME. Receiving DME as prescribed is essential, as patients depend on DME to live and function as independently as possible. The Medicare DME benefit has a profound impact on patients' quality of life.

III. Impact on Beneficiaries' Costs of Obtaining Durable Medical Equipment

CMS estimates that this IFR will cost Medicare beneficiaries \$70 million in cost sharing. While we recognize that this rule will increase costs for certain Medicare beneficiaries, potentially impacting those on the margin, we believe that the increased access to quality DME and supplier/brand name choice is a reasonable trade-off. In addition, the true impact of this forecasted cost-sharing is unclear due to the widespread existence of secondary insurance. Over 80% of traditional Medicare beneficiaries have some type of supplemental coverage, whether it is employer-sponsored, Medigap, or Medicaid.¹ For beneficiaries who are dually eligible for both Medicare and Medicaid, Medicaid will typically pay the cost sharing, offsetting this total amount. In addition, many beneficiaries who do not qualify for Medicaid but cannot afford secondary insurance do not end up paying for DME cost sharing out of pocket. It is common practice for suppliers to write off co-payments when beneficiaries cannot afford to pay after the supplier has made reasonable attempts to collect the balance.

We encourage CMS to monitor how this cost increase impacts beneficiaries, but we believe the increase in access, quality, and choice will offset the legitimate concerns of increased beneficiary cost-sharing.

IV. Termination of Transitional Period

CMS states that the goal of this interim final rule is to preserve beneficiary access to DME items and services in rural and non-contiguous CB areas. CMS states that it will continue to study the impact of the change in payment rates on access to items and services in these areas during the transition period. We support this goal and support the study of the impact of payment rates on access, but also support the study of the impact on choice and quality. However, the transition period is not long enough for CMS to be able to meaningfully assess access, choice and quality in rural and non-contiguous CB areas. The same negative impacts noted over the past year will apply once CMS reduces fees again in six months' time, and beneficiaries who receive DME cannot function in their daily lives without this coverage. We urge CMS to consider increasing the length of the transition period until there is data supporting that an end to the transition period reimbursement rates will not decrease access, choice and quality to durable medical equipment for Medicare beneficiaries.

¹ *An Overview of Medicare*, KAISER FAMILY FOUNDATION (Nov. 2017), <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>.

V. Conclusion

The ITEM Coalition supports the resumption of the transition period for the phase-in of fee schedule adjustments in rural and non-contiguous CB areas. As noted above, we urge CMS to increase the length of the transition period until there is data supporting that an end to the transition period will not decrease access, choice or quality of durable medical equipment for Medicare beneficiaries.

We greatly appreciate your attention to this important issue. Should you have further questions regarding the information contained in our letter, please contact the ITEM Coalition Steering Committee, listed below, or Peter Thomas, ITEM Coalition staff, via email at Peter.Thomas@PowersLaw.com or by calling 202-872-6730.

Sincerely,

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