Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program
Health Status Monitoring
Summary of Findings thru the Third Quarter of 2014

No changes in beneficiary health outcomes resulting from the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program have been observed to date.

The Centers for Medicare & Medicaid Services (CMS) has been actively monitoring the competitive bidding program since it was first implemented in nine Round 1 competitive bidding areas (CBAs) on January 1, 2011. Since the implementation of Round 2 and the national mail-order program for diabetic testing supplies in July 2013, CMS has also been conducting active monitoring across all Round 2 CBAs and in the national mail-order program CBA. All Round 1 and Round 2 CBAs are assigned to one of four DME Medicare Administrative Contractor (MAC) regions, based on their geographic location (Northeast, Midwest, South, and West). This assignment can be found in all workbooks in the "DME Region Map" tab. The national mail-order program CBA includes all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa. CMS monitors three groups of beneficiaries in each of the four DME MAC regions and the national mail-order program CBA.

1. "Enrolled Population"—all people in the CBA enrolled in Original Medicare
2. "Utilizers"—Original Medicare beneficiaries in the CBA who have a claim for one of the competitively bid products
3. "Access Groups"— Original Medicare beneficiaries who are likely to use one of the competitively bid products on the basis of related health conditions. In the case of mail-order diabetic supplies, for example, the relevant access group would be composed of beneficiaries with diabetes.

Within these groups, CMS monitors claims rates and a wide range of health outcomes such as deaths, hospitalizations, emergency room visits, physician visits, admissions to skilled nursing facilities, average number of days spent hospitalized in a month, and average number of days in a skilled nursing facility in a month. We note that we are also monitoring beneficiaries who no longer have claims for a competitively bid item after the program began, beneficiaries who may at some point need the item, and beneficiaries who currently have claims for competitively bid items. The data have not indicated any changes in beneficiary health outcomes in any group. Separate workbooks displaying the aggregate and CBA-level rates for the three groups can be found on the CMS website.

The basic structure of the monitoring efforts considers historical and regional trends in health status. To control for historical trends, each CBA's historical baseline for each rate is provided, beginning in January 2010. Since we cannot develop comparator areas as we did in the Round 1 Rebid, to provide context for the Round 2 CBA rates, historical rates for both Round 1 CBAs and non-CBAs are provided for each of the four DME MAC regions.

In general, Round 2 rates in each DME MAC region are tracking closely to rates for both Round 1 CBAs and non-CBAs both before and after the implementation of Round 2 of competitive bidding. For mail-order diabetic supplies, we provide national rates, as well as historical rates in Round 1 and Round 2 regions for each of the four DME MAC regions. To provide context to overall access to diabetic supplies, we similarly display rates for non-mail-order diabetic supplies, although they are currently not a competitively bid product category. It is important to note that the mortality and morbidity rates commonly display seasonal trends unrelated to the competitive bidding program (e.g., winter months of each year typically have elevated rates of mortality and morbidity). Additionally, rates that appear more variable tend to be based on a smaller number of beneficiaries.

NOTE:

Beginning with public use files utilizing data through the third quarter of 2014, we redefined access groups to include only beneficiaries with ICD-9 diagnosis codes that are considered highly related to product use. Prior to this update, access groups were defined using related condition categories (CCs) based on the Centers for Medicare & Medicaid Services (CMS) beneficiary risk adjustment model. Because Medicare makes periodic updates to its risk adjustment model, the ICD-9 diagnosis codes that are aggregated under a given CC can change over time. As a result, our CC-defined access groups may include ICD-9 diagnosis codes that are not as closely associated with product category usage. Redefining access groups using pre-specified sets of ICD-9 diagnosis codes, instead of CCs, allows us to remove these unrelated diagnoses and improve the accuracy of our access groups.