Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
(DMEPOS) Competitive Bidding Program (CBP)
Health Status Monitoring
Summary of Findings thru the Fourth Quarter of 2022

The Centers for Medicare & Medicaid Services (CMS) continues to observe no negative changes in beneficiary health outcomes resulting from the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP).

CMS has been actively monitoring the DMEPOS CBP since it was first implemented on January 1, 2011. The Round 2021 (R2021) competitive bidding contract performance period for Off-The-Shelf (OTS) Back Braces and OTS Knee Braces began on January 1, 2021, and ends on December 31, 2023. For all other items and services that were previously included in the CBP, there continues to be a temporary gap in competitive bidding. This gap began on January 1, 2019, but CMS continues to monitor claims rates and health outcomes in the previous Round 1 2017 (R1 2017), Round 2 Recompete (R2RC), and the National Mail-Order Recompete (NMORC) competitive bidding areas (CBAs) for all previously competitively bid product categories. Additionally, CMS began monitoring claims rates and health outcomes for current R2021 CBAs for OTS Back Braces and OTS Knee Braces beginning January 2021. R1 2017 CBAs (13 total CBAs) and R2RC CBAs (117 total CBAs) were combined and monitored as one trend line for a total of 130 previous CBAs. Of these 130 CBAs, R2021 monitoring is ongoing in 118 CBAs for OTS Back Braces and 117 CBAs for OTS Knee Braces. No other changes have been made to the monitoring methodology.

All R1 2017, R2RC, and R2021 CBAs are assigned to one of four Durable Medical Equipment (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 NMORC 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 populations in each of the four DME MAC regions and the NMORC CBA.

1. "Enrolled Population"— all people in the CBA enrolled in Original Medicare.
2. "Utilizer Groups"— 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 diabetes supplies, for example, the relevant access group would be composed of beneficiaries with diabetes.

Within these populations, CMS monitors claims rates and a range of health outcomes including deaths, hospitalizations, ER visits, physician visits, admissions to SNFs, average number of days spent hospitalized in a month, and average number of days in a SNF in a month. We also monitor beneficiaries who no longer have claims for a competitively bid item after the DMEPOS CBP began, beneficiaries who may at some point need the item, and beneficiaries who currently have claims for competitively bid items.

The basic structure of the monitoring efforts considers historical and regional trends in health status. Each Excel file contains 48 months of data that captures historical and more recent trends in each health outcome for R1 2017 and R2RC CBAs, R2021 CBAs, and non-CBAs for each of the four DME MAC regions.

Separate workbooks displaying the aggregate level rates for the three populations can be found on the CMS website.

The data have not indicated any negative changes in beneficiary health outcomes in any group through the fourth quarter of 2022.

In general, R1 2017 and R2RC rates, and R2021 rates in each DME MAC region track closely with rates in non-CBAs both before and after the implementation of the programs. Importantly, mortality and morbidity rates commonly display seasonal trends unrelated to the DMEPOS CBP (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.