

# DURABLE MEDICAL EQUIPMENT PAYMENT SYSTEM

payment**basics**

Revised:  
October 2024

Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about \$9.2 billion on DME in calendar year 2023.<sup>1</sup>

DME is defined as equipment that:

- can withstand repeated use,
- primarily and customarily serves a medical purpose,
- generally is not useful to a person without an illness or injury, and
- is appropriate for use in the home.

Medicare Part B covers medically necessary DME prescribed by a clinician. Some examples of DME covered by Medicare include walkers, wheelchairs, and home oxygen equipment and related supplies. Medicare also covers supplies that are necessary for the effective use of DME (e.g., oxygen in oxygen tanks).

Medicare does not cover DME that is unsuitable for use in the home (such as equipment used in hospitals or skilled nursing facilities) or that is intended to help outside the home (such as a motorized scooter for getting around outside the home). In addition, most items that are generally for convenience or comfort (such as grab bars) or disposable supplies not used with DME (such as incontinence pads) are not covered.

## DME fee schedule

Except during periods when competitive bidding was in effect for certain items (see below), Medicare pays for DME using a fee schedule. Fee schedule rates are largely based on supplier charges from July 1986 through June 1987 (updated for inflation) and on information such as unadjusted list prices for products introduced after this period. Medicare payment is equal to 80 percent of the lower of either the actual charge for the item or the fee schedule amount for the item. The beneficiary is

responsible for 20 percent coinsurance after meeting the yearly Part B deductible (\$240 in 2024).

CMS calculates the DME fee schedule amounts for the following DME payment categories.

- *Inexpensive and other routinely purchased items:* These items have a purchase price of \$150 or less; are generally purchased (as opposed to rented) 75 percent of the time or more; or are accessories used in conjunction with certain nebulizers, aspirators, and ventilators. If covered, these items can be purchased new or used. They can also be rented, but total payment amounts cannot exceed the purchase amount for the item.
- *Frequently serviced items:* If covered, these items can be rented as long as they are medically necessary.
- *Oxygen and oxygen equipment:* One bundled monthly payment amount is made for all covered equipment, oxygen, and accessories. Medicare payment for oxygen equipment may not continue beyond 36 months of continuous use. After the 36-month rental cap, Medicare will continue to pay for oxygen and maintenance but not the equipment itself.
- *Other covered items that are necessary for the effective use of DME:* If covered, Medicare pays for the purchase of these supplies.
- *Capped rental items:* These items are not covered in any other DME category and are generally expensive items that have historically been rented. If covered, Medicare generally pays for the rental of these items for a period of continuous use not exceeding 13 months. The fee schedule amount is based on the base-year purchase price and varies by rental month.

Fee schedule amounts are not calculated for certain customized items. If covered,

*The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.*

**MEDPAC**

425 I Street, NW  
Suite 701  
Washington, DC 20001  
ph: 202-220-3700  
www.medpac.gov

Medicare pays a lump sum amount for the purchase of the item, as determined by the Medicare administrative contractor.

### **Competitive bidding**

Beginning in 2011, CMS has paid for certain types of products in specified areas under a competitive bidding program (CPB). Although the CPB has not been in effect in every year since 2011, it has driven down the cost of DME considerably for both Medicare and beneficiaries. Compared with payment rates in the year before competitive bidding, Medicare's payment rates for some of the highest-expenditure DME products have fallen by an average of nearly 50 percent with no documented effect on beneficiary health outcomes. In 2012, CMS estimated that competitive bidding would save more than \$42 billion over 10 years—\$25 billion in savings for the program and \$17 billion in savings for beneficiaries.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the phase-in of a CBP for selected DME, prosthetics, orthotics, and related supplies, starting in 2008. Under the CBP, suppliers that want to furnish designated products in a competitive bidding area (CBA) submit a bid. Bids are evaluated based on the supplier's eligibility, financial stability, and bid price. Contracts are awarded to the suppliers who offer the best price and meet applicable quality and financial standards. For each item, the payment amount—referred to as the single payment amount (SPA)—is derived from the maximum of all winning bids for the item.<sup>2</sup> Suppliers awarded contracts (i.e., contract suppliers) must agree to accept assignment on all claims for bid items and be paid the SPA.

The first round of competitions took place, and contracts were awarded, effective July 1, 2008. However, the Medicare Improvements for Patients and Providers Act of 2008 terminated the contracts awarded in the first round and required CMS to rebid the competition.

In 2011, CMS rebid the canceled round; that round was known as "Round 1 rebid."

CMS has conducted two additional rounds of competitions (i.e., "recompetes") in the same Round 1 areas. These rounds are referred to as "Round 1 recompetete" and "Round 1 2017." CMS also conducted competitions in additional areas beginning in July 2013, referred to as "Round 2" and "Round 2 recompetete." In addition, CMS implemented the National Mail-Order Program for diabetes testing supplies in July 2013. As the name implies, this competition covered the entire country, including both urban and rural areas, but applied only to diabetes testing supplies purchased on a mail-order basis.

All rounds of the CBP expired on December 31, 2018. In 2019 and 2020, there was a temporary gap period during which no rounds of competitive bidding were active. Beginning in 2021, CMS proposed adding multiple new product categories to the CBP and combining Rounds 1 and 2 into one round referred to as "Round 2021." However, before the round was implemented, CMS removed all but two product categories, both of which had not previously been included in competitive bidding: off-the-shelf (OTS) back braces and OTS knee braces. To date, CMS has not proposed a new round for the National Mail-Order Program for diabetes testing supplies.

During the temporary gap period (2019 and 2020) and in 2021 and 2022 (for products not included in Round 2021), CMS allowed any willing supplier to furnish DME products in former CBAs on a fee schedule basis.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act set DME prices for March 6, 2020, to the end of the coronavirus public health emergency. DME rates in areas subject to competitive bidding were set to equal the CBP rates updated annually for inflation.

The CARES Act also established rates for non-CBAs. For rural and noncontiguous non-CBAs, rates were equal to a 50/50 blend of CBP-derived rates and the historical fee schedule rates. For urban, contiguous non-CBAs, rates were set at a 75/25 blend of CBP-derived rates and

the historical fee schedule. CMS estimates that the 50/50 and 75/25 blends increase Medicare's payment rates by 66 percent and 33 percent, respectively.

CMS paused the next round of competitive bidding to set rates for CBP areas in 2024. For 2025, the rates for items and services subject to competitive bidding in CBAs will be the prior year's rate (based on the last round of bidding conducted) updated by inflation, with the same rates also applying to urban areas not subject to competitive bidding. For rural areas, DME rates will be

set at a 50/50 blend of the CBP rate and the historical fee schedule. ■

- 1 These amounts include payments for DME, prosthetics, orthotics, and supplies, a category to which DME belongs under Medicare. The reported expenditures reflect a significant increase in suspected fraudulent utilization of certain intermittent urinary catheter services during 2023.
- 2 Prior to Round 2021, SPAs were set using the median (instead of the maximum) of all winning bids for an item. CMS finalized this and other changes to the CBP in a November 2018 final rule (83 FR 56922).