

**Testimony of
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**Before the
House Committee on Small Business
Subcommittee on Rural and Urban Entrepreneurship
On
DMEPOS Competitive Bidding Program**

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Good morning Chairman Shuler, Ranking Member Fortenberry, and distinguished members of the Subcommittee. I am pleased to be here today on behalf of the Centers for Medicare & Medicaid Services (CMS) to discuss the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program mandated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This major initiative will reduce beneficiary out-of-pocket costs, improve the accuracy of Medicare's DMEPOS payments, help combat supplier fraud, ensure beneficiary access to high quality DMEPOS items and services, and save taxpayers billions of dollars.

Overview

CMS is the largest purchaser of health care in the United States, serving over 92 million Medicare, Medicaid, and SCHIP beneficiaries. Medicare alone covers roughly 44 million individuals, with total gross Medicare benefit outlays and administrative costs projected to reach approximately \$499 billion in Fiscal Year (FY) 2009.¹ CMS projects that gross spending for Medicare will equal approximately \$8.7 billion on DME alone in 2009. Each year, DMEPOS suppliers provide items and services including power wheelchairs, oxygen equipment, walkers and hospital beds to millions of Medicare beneficiaries.

Medicare currently pays for DMEPOS items and services using fee schedule rates for covered items. In general, fee schedule rates are calculated using historical supplier

¹ Department of Health and Human Services, Budget in Brief: FY 2009.

charge data from about 20 years ago that may not be reflective of an appropriate payment amount for today's market. Relying on historical charge data has resulted in Medicare payment rates that are often higher than prices charged for identical items and services when furnished to non-Medicare customers. Medicare beneficiaries and taxpayers bear the cost of these inflated charges. Table 1 shows the differences between the current CMS fees for certain devices compared to the average prices a consumer would see if shopping for that device on the Internet.

Table 1: Illustrative Comparison Prices Pre-Competitive Bidding

<i>DMEPOS Device (rank by use)</i>	<i>CMS Fee (% above average internet price)</i>	<i>Illustrative Average Internet Pricing</i>	<i>CMS payment above average internet price</i>
Oxygen concentrator (#1)	\$2,380 (+352%)	\$677	\$1,703
Standard power mobility device (#3)	\$4,023 (+185%)	\$2,174	\$1,849
Hospital bed (#4)	\$1,825 (+242%)	\$754	\$1,071
Continuous positive airway pressure device (#5)	\$1,452 (+517%)	\$281	\$1,171
Respiratory assist device BIPAP (Bi-level Positive Airway Pressure) (#18)	\$3,335 (+247%)	\$1,348	\$1,987

Under the new DMEPOS competitive bidding program, beginning in 10 metropolitan statistical areas (MSAs) on July 1, 2008, Medicare payment to suppliers for certain equipment and supplies will be calculated based on competitive bids submitted by accredited suppliers that meet both quality and financial standards. Suppliers who meet all of the requirements of the program and submit bids in the winning range will be awarded contracts in designated competitive bidding areas. These Medicare contract suppliers will then serve beneficiaries in the 10 competitive bid areas and will be monitored by CMS on their performance, quality and customer service. Requiring suppliers to submit bids, including information on price, accreditation, and financial standards will ensure continued access to high-quality medical equipment and supplies at more reasonable prices to beneficiaries and the Medicare program. These changes, which

result in more accurate pricing and improved oversight, also support CMS' efforts to reduce Medicare waste, fraud and abuse.

Beneficiary Savings

The success story of DMEPOS competitive bidding is reflected in the amount of money that beneficiaries will save as a result of lower coinsurance across the board for these products. Competitive bidding will successfully reduce the amount Medicare will pay for these items and has brought the payment amounts in line with that of a competitive market. When fully implemented in 2010, the program is projected to save Medicare and taxpayers \$1 billion annually² – and these savings will directly translate to lower coinsurance for beneficiaries. Further, the projected overall savings to Part B of the Medicare program should slow the annual increase of the Part B premium Medicare beneficiaries pay each month.

Across all 10 MSAs participating in the initial phase of competitive bidding and in each product category, beneficiaries will see an average savings of 26 percent when the new payment rates go into effect on July 1, 2008. For example, beneficiaries in Orlando who use oxygen will save 32 percent. Before competitive bidding, Medicare paid \$199.28 a month for oxygen rental in Orlando and, after the bid process; the price will be reduced to \$140.82 per month. The beneficiary, who has been paying coinsurance of \$39.86 per month, will soon be paying \$28.17 per month, a savings of \$140 per year. In Charlotte and Cincinnati, beneficiaries will save 30 percent, Miami beneficiaries will save 29 percent, Pittsburgh 28 percent, Cleveland 27 percent, Kansas City 25 percent, Dallas 23 percent and Riverside 22 percent³.

Average savings generated for some commonly used items, for which Medicare pays 80 percent and beneficiaries pay 20 percent of the allowed amount following payment of the

² Federal Register, April 10, 2007, page 18079

³ CMM data derived from bid results

annual Part B deductible, is summarized in the following chart⁴:

Examples of Medicare and Beneficiary Savings

Item/Period of Service	Current Allowed Amount**	New Allowed Amount**	Medicare Savings 80% of Difference	Beneficiary Savings 20% of Difference
Concentrator				
Per month	\$199.28	\$140.82	\$46.77	\$11.69
Per year	\$2,391.36	\$1,689.84	\$561.24	\$140.28
Per 3 years*	\$7,174.08	\$5,069.52	\$1,683.72	\$420.84
Hospital Bed				
Per month	\$140.46	\$99.28	\$32.94	\$8.24
Per 13 months*	\$1,474.78	\$1,042.46	\$345.86	\$86.46
Diabetic Supplies				
Per month	\$82.68	\$47.53	\$28.12	\$7.03
Per year	\$992.16	\$570.36	\$337.44	\$84.36
Per 3 years	\$2,976.48	\$1,711.08	\$1,012.32	\$253.08

* Beneficiary takes over ownership of equipment after end of rental payment period

** 20% of current and new allowed amount is paid by the beneficiary out-of-pocket

In the competitive bidding areas, Medicare suppliers are currently paid based on fee schedule amounts that average \$82.68 per month for diabetic testing supplies (100 lancets and test strips) of which the beneficiary pays 20 percent (approximately \$16.54 per month on average). The payment is the same regardless of whether the supplies are mailed to the beneficiary's home or purchased at local stores (e.g., pharmacies). Under the competitive bidding program, the average Medicare-allowed monthly payment amount for these supplies in the competitive bidding areas will be reduced by 43 percent from \$82.68 to \$47.53, in those cases where the beneficiary chooses to obtain the supplies on a mail order basis. If the beneficiary does not wish to receive their replacement testing supplies in the mail, they can elect to obtain them from a local store with no reduction in the allowed payment amount or beneficiary coinsurance amount.

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<http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2993&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date>

Quality and Financial Standards

The program provides important safeguards to ensure high quality, good customer service, and improved oversight. These safeguards also ensure a level playing field for suppliers competing for contracts under the competitive bidding program.

Quality and Accreditation Standards. The MMA required the establishment of quality standards for DMEPOS suppliers to be applied by independent accreditation organizations. The quality standards address the set up and delivery of items and services, beneficiary education on the use of these products, suppliers' accountability, business integrity, performance management, and other areas. CMS conducted a wide variety of activities to involve stakeholders (including many targeted specifically for small business suppliers) and the public in development of these standards. Specifically:

- We conducted focus groups early in this process to provide small suppliers with an opportunity to share concerns about the impact quality standards would have on their businesses.
- We consulted with various stakeholders, including small supplier business owners, physicians, homecare association members, trade association members, accreditation organizations, clinical experts, and industry attorneys.
- We presented draft quality standards to the Program Advisory and Oversight Committee (PAOC) to provide advice on the Medicare DMEPOS competitive bidding program and quality standards.
- On September 26, 2005, we posted the draft standards on our web site for a 60-day public comment period that ended November 28, 2005.
- We held a special Open Door Forum to explain the draft quality standards and to solicit comments.

CMS received more than 5,600 public comments on the draft quality standards. Based on these comments, we made significant revisions to reduce the burden on small suppliers while continuing to ensure quality services for Medicare beneficiaries. All suppliers selected as Medicare contract suppliers in Round I of the competitive bidding program

must be accredited under these standards, and all DMEPOS suppliers nationally must be accredited by September 30, 2009.

Financially viable business partners. The MMA also requires that suppliers meet financial standards in order to contract with Medicare under the competitive bidding program. These financial standards allow Medicare to assess the ability of suppliers to provide quality items and services in sufficient quantities to meet beneficiaries' needs. Ultimately, financial standards for suppliers will help maintain beneficiary access to quality items and services by ensuring that contract suppliers are viable entities able to consistently provide quality items and services to patients for the life of their contracts. They also help to weed out disreputable operators that prey on Medicare and beneficiaries from legitimate suppliers acting in the best interests of their patients. As part of bid solicitation, each supplier submitted required financial documentation, including balance sheets, statements of cash flows, and profit and loss statements from tax returns. CMS evaluated each bidder's financial documentation to determine whether the supplier had met the standards required to participate in the program.

It is important to note that the financial documentation requirements were crafted in a way that considers small suppliers' business practices and constraints, while remaining consistent with the financial standards mandate of the MMA. We have limited the number of financial documents that a supplier must submit so that the requirement will be less burdensome for all suppliers, including small suppliers. We believe we have balanced the needs of small suppliers with the needs of beneficiaries in requesting documents that will provide us with sufficient information to determine the financial soundness of a supplier, regardless of its size.

Final Regulations

Two of the goals of CMS' final regulations implementing the competitive bidding program were ensuring that beneficiaries maintained access to quality items and services, and that small suppliers had an opportunity to participate in the program.

Beneficiary protections. We anticipate that competitive bidding will save money for beneficiaries and taxpayers, while ensuring beneficiary access to high-quality items. The following are specific examples of the beneficiary protections established in the competitive bidding program:

- Contract suppliers must be accredited and meet the newly established financial and quality standards, and DMEPOS quality standards and accreditation requirements and, as a result, will maintain a business model that that supports quality, customer service, and access to care for beneficiaries. The independent accrediting organizations will play a key role in ensuring that contract suppliers continue to meet these quality standards.
- CMS' regulations require that multiple contract suppliers are selected to meet beneficiary demand in each competitive bidding area. This means that beneficiaries will have access to the services they need and that competition among winning suppliers, based on quality, customer service, will provide beneficiaries with choices regarding the source of their medical equipment and supplies.
- For the first time in the history of the Medicare program, the performance of suppliers will be monitored through beneficiary satisfaction surveys that measure their level of satisfaction with the services they receive from contract suppliers.
- Beneficiaries will have no financial liability to a non-contract supplier unless they are presented with and sign an advance beneficiary notice before a product is furnished to them. This protects beneficiaries from inadvertent financial liability in excess of what a contract supplier could offer
- When a physician specifically prescribes a particular brand name product or mode of delivery to avoid an adverse medical outcome, contract suppliers are required either to furnish that item or mode of delivery, to assist the beneficiary in finding another contract supplier in the competitive bidding area that can provide that item or service,

or to consult with the physician to find a suitable alternative product or mode of delivery for the beneficiary.

- Beneficiaries will be able to obtain repairs of equipment they own from either a contract or non-contract supplier with a valid Medicare billing number.
- Replacement parts needed to repair beneficiary-owned equipment may also be obtained by a beneficiary from either a contract or non-contract supplier with a valid Medicare billing number, even if the parts are competitively bid items.
- Contract suppliers are required to make available the same items to beneficiaries that they make available to non-Medicare customers. For transparency, we will post on our web site a list of brands furnished by each contract supplier.
- Under the grandfathering rules, a beneficiary will have the opportunity to make arrangements with a non-contract supplier that will allow the beneficiary to continue to receive certain rented items from the same supplier (grandfathered supplier) that had been furnishing the item to the beneficiary before the implementation of the competitive bidding program, provided the supplier is willing to do so. If a non-contract supplier agrees to furnish "grandfathered" items to one beneficiary, it must furnish those items to all beneficiaries who elect to continue receiving the grandfathered items from that supplier.

Small Supplier Considerations: In developing this important new program, CMS worked closely with suppliers, manufacturers and beneficiaries through a transparent public process. This process included many public meetings and forums, the assistance of the PAOC (which included representation from the small supplier community), small business and beneficiary focus groups, notice and comment rulemaking, and other opportunities to hear the concerns and suggestions of stakeholders. As a result, CMS' policies and implementation plan pay close attention to the concerns of these constituencies, in particular those of small suppliers.

The first round of the DMEPOS competitive bidding program is now complete. During the implementation of this program, CMS adopted numerous strategies to ensure small suppliers have the opportunity to be considered for participation in the program. For example:

- CMS worked in close collaboration with the Small Business Administration to develop a new, more appropriate definition of “small supplier” for this program. Under this definition, a small supplier is a supplier that generates gross revenues of \$3.5 million or less in annual receipts including Medicare and non-Medicare revenue rather than the previous standard of \$5 million. We believe that this \$3.5 million standard is representative of small suppliers that provide DMEPOS to Medicare beneficiaries.
- Further, recognizing that it may be difficult for small suppliers to furnish all the product categories under the program, suppliers are not required to submit bids for all product categories. The final regulation implementing the program allows small suppliers to join together in “networks” in order to meet the requirement to serve the entire competitive bidding area.
- In addition, to help ensure that there are multiple suppliers for all items in each competitive bidding area (CBA), each bidder’s estimated capacity, for purposes of bid evaluation only, was limited to 20 percent of the expected beneficiary demand for a product category in a CBA. This policy ensures that multiple contract suppliers for each product category were selected and that more than enough contract suppliers are selected to meet demand for items and services in area. For most areas and product categories, the result of this policy will be an increase of the number of contracts awarded by CMS beyond the statutory threshold of two contracts per product category per CBA.

- The regulation also established a 30 percent target for small supplier participation in the program.

CMS recognizes that under existing Medicare law and policies, physicians and other treating professionals sometimes supply certain items of DMEPOS to their patients as part of their professional service. The competitive bidding program preserves this physician-patient relationship by allowing physicians and other treating practitioners to continue supplying certain items to their patients without participating in the bidding process.

Considerations for Low Population Density Areas and Rural Areas:

The statute also provides CMS with discretionary authority for exempting low population density areas within urban areas and rural areas that “are not competitive” from competitive bidding unless there is a significant national market through mail order for a particulate item or service. In the final rule, we indicated that we were finalizing our proposal to allow for the use of this authority if data indicated that an area was not competitive based on one or more of the following indicators:

- Low utilization of DMEPOS items by Medicare beneficiaries receiving fee-for-service benefits relative to similar geographic areas;
- Low number of suppliers of DMEPOS relative to other similar geographic areas; and
- Low number of Medicare beneficiaries receiving fee-for-service benefits in the area relative to other similar geographic areas.

For Round 1, we used this discretionary authority to exempt a large portion of Eastern Riverside and San Bernardino Counties in the Riverside MSA. We also exempted whole counties in the Dallas, Cincinnati, and Kansas City MSAs. We determined that these areas had population densities that were too low relative to other parts of the MSA and that the allowed charges for DMEPOS items attributed to these areas were low relative to the MSA as a whole, indicating that the areas were not competitive when compared to other parts of the MSA. We will use a similar process to determine which areas might be

exempted during Round Two.

The Bidding Process

The initial round of DMEPOS competitive bidding (Round 1) officially closed on September 25, 2007. We received a total of 6,209 bids for the competitively bid products across all 10 Metropolitan Statistical Areas (MSAs) in which CMS is proceeding with competitive bidding. Of the bids received, 1,335 were winning bids. Our target for small supplier participation was exceeded, with 64 percent of contracts offered to small suppliers during the initial round of contract offers. Winning bids were offered a contract and as of April 18, 2008, 1,254 contracts have been signed by suppliers, a 96 percent acceptance rate. We are aware that a number of suppliers had their bids disqualified, and the majority of these were for failing to submit the supporting financial documentation that was outlined in the Request for Bids. This documentation is critical for determining whether suppliers meet financial standards, as required by the MMA. These standards are essential to ensure that Medicare contracts only with financially sound suppliers capable of serving beneficiaries needs over the life of the contract.

In order to ensure that bidders were fully informed about this new program, CMS made a significant effort to educate and communicate with potential bidders on the bidding process, including the required documentation, and the rules and procedures for submitting a successful bid. Preliminary education began months before the final regulation was issued, and the formal education campaign began on April 2, 2007, the day the final regulation was released. Also in April 2007, CMS hosted a special Open Door Forum on DMEPOS competitive bidding in which more than 1,000 suppliers participated. Prior to opening the supplier bid window on May 15, 2007, CMS established a dedicated website⁵, with a comprehensive array of important information for suppliers, including a tool kit, fact sheets, webcasts, and questions and answers. CMS also held Open Door Forums, bidders' conferences, and sent listserv announcements in order to disseminate key information about the program.

⁵ www.dmecompetitivebid.com

Outreach

CMS is making great efforts to ensure the program's success. Our outreach plan includes extensive communication to four major categories of stakeholders: beneficiaries, partner groups (the local Area Agencies on Aging, the State Health Insurance Assistance Programs (SHIPs), beneficiary advocacy groups and other local organizations that come in contact with Medicare beneficiaries), providers (doctors, social workers, discharge planners and others), and DMEPOS suppliers (including the new contract suppliers, non-contract suppliers and grandfathered non-contract suppliers).

Our beneficiary outreach will include a direct mailing to all beneficiaries in the Round 1 MSAs, which will contain a letter, a brochure that outlines the new program and a list of all Medicare DMEPOS contract suppliers in their MSA. A beneficiary fact sheet is also available, and will be available through partner groups and providers. We will also rely heavily on our partner groups to assist in this transition. My staff and I have been in contact with, and will continue to meet with, partner groups to educate them on this program and ask for support as the program is implemented.

Provider outreach includes doctors, social workers, referral agents, discharge planners and others. This information is delivered through the Center for Medicare Management listservs, Medicare Learning Network Matters articles, training sessions, and teleconferences. Provider outreach aims to educate providers on how to communicate with the beneficiary about this new program and where to refer their Medicare beneficiaries who need DMEPOS. The communication pieces are delivered through the same avenues as the technical program requirements as well as through local and national medical, social work, referral agent and discharge planning organizations. We are considering conducting a direct mailing to providers as well.

DMEPOS suppliers are reached through the provider outreach method as well as through the Competitive Bidding Implementation Contractor (CBIC). Throughout the bidding process, the CBIC, in conjunction with CMS, delivered information and messages to suppliers to assist in understanding the program and its requirements through email

messages, the CBIC website, bidders' conferences, teleconferences and direct conversations. Soon, a program manual outlining technical program requirements including policies and claims processing requirements will be available to suppliers on the CMS website. All suppliers, including the new contract suppliers, non-contract suppliers and grandfathered non-contract suppliers should be receiving an email notice that information about the program requirements is available.

Our outreach strategy is administered both at the national and the regional level. Our CMS Regional Office staff has targeted local organizations, including local Chambers of Commerce, State Departments of Insurance and local elected officials to request that they share information with their members or constituents.

Once the program begins, Regional Offices will respond to general inquiries from beneficiaries and stakeholders and may refer inquiries/complaints that are beneficiary or claims specific to 1-800-MEDICARE, which will be the primary point of contact for beneficiaries. Inquiries and complaints may also be referred to the DME claims processing contractor or local ombudsman depending upon their nature and scope. Inquiries and complaints will be tracked for internal reporting purposes.

In order to ensure that beneficiaries are able to access quality DMEPOS, we will be monitoring the program closely at multiple levels. CMS is committed to ensuring a smooth transition for beneficiaries, providers and suppliers when the new payment rates take effect on July 1, 2008.

- The performance of contract suppliers will be monitored through beneficiary satisfaction surveys that measure beneficiaries' level of satisfaction with the services they receive under the competitive bidding program.
- CMS will track the number of questions SHIPs receive about DMEPOS issues.
- CMS will track the volume of questions and requests for DMEPOS information on 1-800-MEDICARE.
- CMS will track payments and claims to non-contracted suppliers for grandfathered supplies.

- CMS will track the number of Advance Beneficiary Notices (ABNs) issued by non-contract suppliers in a competitively bid area (CBA) for competitively bid items.
- CMS will track the shift from non-contract to contract suppliers for the DMEPOS competitively bid products, comparing before and after July 1 and over time.

Conclusion

The first round of the competitive bidding process has proven to be successful. Medicare beneficiaries in CBAs will realize, on average, a 26 percent savings on certain commonly used DMEPOS, and small suppliers account for 64 percent of the winning bids. CMS has taken care to implement this program in a way that emphasizes the needs of beneficiaries while addressing the concerns of small suppliers. CMS has already begun a comprehensive outreach and education campaign in order to ensure a smooth transition for beneficiaries come July 1. We set out to provide beneficiaries with quality DMEPOS, at a lower price, from reliable suppliers in communities. We have lower prices, we have reliable suppliers and we are in the process of educating beneficiaries and suppliers about this new program. Our extensive monitoring network will signal any issues that arise and allow us to move to correct them quickly and efficiently.