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ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515–6115

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MEMORANDUM

September 13, 2010

To: Members of the Subcommittee on Health

Fr: Health Subcommittee Staff

Re: Subcommittee hearing: "Medicare's Competitive Bidding Program for Durable Medical Equipment: Implications for Quality, Cost and Access"

On Wednesday, September 15, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Medicare's Competitive Bidding Program for Durable Medical Equipment: Implications for Quality, Cost, and Access." The hearing will examine the conception and implementation of the competitive bidding program, the implementation of the Round 1 re-bid, and its potential effects on patients, providers, and suppliers.

I. BACKGROUND ON DURABLE MEDICAL EQUIPMENT IN MEDICARE

The Medicare program covers durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS, or DME) under Part B, the Supplementary Medical Insurance program[1]. Commonly furnished items under this benefit include standard and power wheelchairs, oxygen concentrators and tanks, hospital beds, diabetic testing supplies, walkers, and enteral nutrients and supplies. In FY2009, approximately 9.85 million Medicare beneficiaries used Medicare-covered DMEPOS.[2] In 2008, Medicare spent $10.6 billion on DMEPOS (excluding cost-sharing

[1] Section 1832(a)(2)(G), 1834(a)(13), and Section 1861(n) of the Social Security Act.

[2] Morgan, P.C., April 28, 2010., Congressional Research Service, "Medicare Durable Medical Equipment: the Competitive Bidding Program."

and deductibles paid by beneficiaries).[3] In April of 2009, there were approximately 107,000 DMEPOS suppliers eligible to bill the Medicare program.[4]

Since 1989, according to provisions of the Omnibus Reconciliation Act of 1987, Medicare has paid for DMEPOS according to a fee schedule based on prices in use during 1987.[5] Medicare pays for the lesser of 80% of the fee schedule amount or the actual charge for an item, less any unpaid deductible. The beneficiary is responsible for any unpaid deductible and the remaining 20% coinsurance.[6] Those prices have been updated according to inflationary adjustments, payment reductions, or other updates, according to statute, since that time.[7]

Wheelchairs, oxygen equipment, prosthetics, and other DMEPOS items are essential treatment to allow beneficiaries with disabilities and other conditions to improve or maintain their health and to live independently at home. DMEPOS can replace the functions of lost limbs or other disabilities. However, persistent problems in overpayments and fraud in the DMEPOS benefit have led to excess costs for beneficiaries and taxpayers.[8,9] Overpayments for DMEPOS are particularly a problem for beneficiaries, because beneficiaries bear 20% of the cost of Part B items and services, which can be significant relative to the income and assets of beneficiaries.

II. ISSUES IN PRICING AND INTEGRITY OF DMEPOS

Pricing. Numerous reports over several decades have documented overpayments in the DMEPOS fee schedule. GAO in 1998 noted that because the DMEPOS fee schedule is based on charges used in 1987, prices used for the fee schedule today may have little relation to prices in the market.[10]

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[3] *Ibid.*

[4] *Ibid.*

[5] CMS, "Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedules", http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1231049&intNumPerPage=10

[6] *Ibid.*

[7] *Ibid.*

[8] Government Accountability Office, 2009, GAO – 10 – 27, "CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program."

[9] HHS Office of the Inspector General, 1997, OEI-04-96-00240, "Medical Equipment Suppliers: Assuring Legitimacy."

[10] United States General Accounting Office, 1998, GAO – HEHS – 98 – 102. "Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies."

In 2006, for example, the HHS Office of the Inspector General (OIG) reported that Medicare would allow $7,215 in payments over 36 months to oxygen suppliers for oxygen concentrators that cost $587, on average, to purchase.[11] In 2004 the OIG reported that median Medicare price in 2003 for standard power wheelchairs was $5,297, compared to median retail prices of $3,863 and median wholesale prices of $2,363.[12] In 2009, the OIG reported that in 2007 Medicare allowed $4,018 for standard power wheelchairs that cost suppliers $1,048 to acquire.[13]

Critics of this market comparison analysis argue that comparison to widely available market prices is inappropriate because Medicare suppliers deliver services beyond the DMEPOS item itself, such as delivery and emergency repair visits. However, the OIG found that oxygen concentrators and other equipment require minimal servicing by the supplier, and that beneficiaries are able to perform routine servicing after training by the suppliers at the time of delivery.[14]

Congress has acted to limit Medicare expenditures for DMEPOS and otherwise modify the program several times over the last fifteen years. The Balanced Budget Act of 1997 (P.L. 105-33), the Medicare Prescription Drug, Improvement, and Modernization and Act of 2003, the Deficit Reduction Act of 2005 (MMA; P.L. 108-173), the Medicare Improvements for Patients and Providers' Act of 2008 (MIPPA; P.L. 110-275) and the Patient Protection and Affordable Care Act of 2010 (P. L. 111 - 48) all contained provisions that reduced prices paid or restructured payment methodologies for wheelchairs, oxygen therapy equipment, or other DMEPOS.

Program Integrity. In addition to overpayments for DMEPOS, numerous studies have documented a high rate of fraud and abuse among DMEPOS suppliers.

The Medicare Payment Advisory Commission (MedPAC), in its December, 2009, report on regional variation in Medicare spending, noted that DME spending varies dramatically among counties very near one another. Spending in Miami-Dade county was 5-10 times the amount of spending per beneficiary of neighboring Collier, Monroe, and Broward counties and more than 7

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[11] Office of the Inspector General, U.S. Department of Health and Human Services, 2006, OEI-09-04-00420, "Medicare Home Oxygen Equipment: Cost and Servicing."

[12] Office of the Inspector General, U.S. Department of Health and Human Services, 2004, OEI-03-03-00460, "Comparison of Prices for Power Wheelchairs in the Medicare Program."

[13] Office of the Inspector General, U.S. Department of Health and Human Services, 2009, OEI-04-07-00400. "Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services."

[14] *Ibid.*

times the national average.[15] MedPAC concluded that this variation has raised concerns about fraud in the program.

The Office of the Inspector General has documented problems with supplier enrollment that allow fraudulent suppliers to enter the program, the first step towards fraudulent billing. For example, on a site visit to south Florida in 2006, the OIG found that 45% of suppliers in that area did not meet basic standards for program enrollment, including 31% of suppliers in that area that did not maintain a physical office or staff during business hours.[16] Nationwide, in a non-representative sample of 169 suppliers, the OIG found that 10 (6%) did not exist at their physical address but nonetheless billed the program for significant amounts of DMEPOS.[17] In 1997, the OIG concluded that "the ease and low expense of acquiring a supplier number facilitates entry of abusers into the program."[18] The GAO, in 2008, easily achieved enrollment into the Medicare program for two fictitious DMEPOS companies using simple methods of deception such as false names and bank accounts.[19]

CMS has implemented program safeguards that should address some deficiencies described above. In the fall of 2009 CMS implemented new quality accreditation requirements for DME suppliers. Those requirements are meant to ensure that suppliers meet minimum standards of accessibility, business integrity, and quality to participate in the Medicare program.[20] CMS also implemented a Congressional mandate in 2009 that DME suppliers post a $50,000 surety bond to help offset fraud risk.[21]

In addition to problems identified with supplier enrollment, the OIG has also identified many instances of improper payments to DMEPOS suppliers through violations of Medicare

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[15] The Medicare Payment Advisory Commission, 2009, "Report to Congress: Measuring Regional Variation in Service Use."

[16] HHS Office of the Inspector General, 2007, OEI-03-07-00150, "South Florida Suppliers' Compliance with Medicare Standards: Results from Unannounced Site Visits."

[17] HHS Office of the Inspector General, 2007, OEI-04-05-00380, "Medical Equipment Suppliers: Compliance with Medicare Enrollment Requirements."

[18] HHS Office of the Inspector General, 1997, OEI-04-96-00240, "Medical Equipment Suppliers: Assuring Legitimacy."

[19] Government Accountability Office, 2008, GAO – 08 – 955, "Covert Testing Exposes Weaknesses in the Durable Medical Equipment Screening Process."

[20] Centers for Medicare & Medicaid Services, "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation Fact Sheet", http://www.cms.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationMIPPA-FactSheet.pdf

[21] 42 Code of Federal Regulations, Section 424.57.

coverage rules and billing practices. For example, in a review of payments for support surfaces (which provide treatment or prevention of bedsores), the OIG found that 86% of claims did not meet Medicare's coverage criteria, including 38% of claims that were undocumented, 22% that were not medically necessary, and 17% that had insufficient documentation.[22] In a review of certain DMEPOS claims requiring extra documentation for one region, the OIG found that more than half of claims paid were improperly documented.[23]

The recent health reform legislation contained numerous anti-fraud provisions that will assist CMS, the OIG, and the Justice Department in identifying abusive suppliers and fraudulent billing practices, including new authorities to screen providers before they enter the program, new requirements that physicians that order DME be enrolled in the Medicare program, new data-sharing and data-collection provisions, enhanced penalties for fraudulent providers, and new funding to identify, prevent, and punish fraudulent providers.[24]

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[22] HHS Office of the Inspector General, 2009, OEI-02-07-00420, "Inappropriate Medicare Payments for Pressure Reducing Support Surfaces", See also: HHS Office of the Inspector General, 1997, OEI-02-95-00370, "Pressure Reducing Support Surfaces."

[23] HHS Office of the Inspector General, 2010, A-04-09-04039, "Review of Jurisdiction C Medicare Payments for Selected Durable Medical Equipment Claims with the KX Modifier for Calendar Year 2007," See also: HHS Office of the Inspector General, 2008, A-09-05-00063. "Review of Medicare Payments to iCare Medical Supply for Home Blood-Glucose Test Strip and Lancet Supplies."

[24] Sections 6401 – 6411 of P.L. 111-48.

III. DEMONSTRATIONS OF COMPETITIVE BIDDING IN THE MEDICARE PROGRAM

Competitive bidding can, in principle, use market incentives to lower the prices Medicare pays for DMEPOS. In exchange for the chance to remain in the program or to increase their market share, competing suppliers will reveal the price they are willing to accept in exchange for items and services.[25] Those prices could be lower than the fee schedule amount Medicare otherwise uses. Because beneficiaries pay 20% of the cost of DMEPOS, plus any unmet deductible, any savings achieved through competitive bidding would also reduce beneficiary out of pocket medical expenses.

The Balanced Budget Act of 1997 mandated that the Secretary of Health and Human Services conduct demonstrations on competitive bidding for DMEPOS to test that idea in Medicare and to determine whether competitive bidding would have any impact on access and quality.[26] CMS (then the Health Care Financing Administration) conducted 2 rounds of competitive bidding in Polk County, FL and one round in San Antonio Texas, over the years 1999 - 2001.[27]

The evaluation of the competitive bidding program found that it reduced Medicare costs by 19 percent, on average, for the five categories of DMEPOS subjected to bidding. No significant changes in access to supplies or changes in utilization were observed. The quality of services provided to beneficiaries at delivery of DMEPOS did not diminish; and the product selection offered to beneficiaries was not reduced.[28]

The MedPAC recommended in June 2003 that CMS be given the authority to conduct competitive pricing demonstrations, and the authority to implement competitive pricing nationwide if demonstrations are successful.[29]

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[25] King, Kathleen. Government Accountability Office, 2008, GAO – 08 – 767T, "Testimony Before the Subcommittee on Health, Committee on Ways and Means: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical."

[26] Section 4319 of P.L. 105-33

[27] Secretary Tommy Thompson, 2004, "Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies", https://www.cms.gov/DemoProjectsEvalRpts/downloads/CMS_rtc.pdf.

[28] *Ibid.*

[29] Medicare Payment Advisory Commission, June, 2003. *Variation and Innovation in Medicare. Chapter 8: Using Market Competition in Fee-For-Service Medicare.*

IV. THE COMPETITIVE BIDDING PROGRAM: ROUND 1 IMPLEMENTATION AND SUBSEQUENT LEGISLATION

The MMA mandated that CMS adopt competitive bidding-based pricing for DMEPOS on a phased-in basis beginning in 2007. The Act mandated two rounds of bidding in MSAs, followed by optional additional MSAs after those rounds. In addition, after the initial two rounds of competition, the MMA granted CMS the authority to use pricing observed in competitive bidding MSAs in areas outside those MSAs.[30]

CMS conducted the bidding for Round 1 of the DMEPOS competitive bidding program in 2007. The program was implemented in 10 competitive bidding metropolitan statistical areas beginning on July 1, 2008. Average price reductions of 26% were observed across product categories and MSAs.

Implementation of Round 1 was marred by several problems that caused confusion among DMEPOS suppliers. CMS delayed the bid window deadline several times; provided bidding instructions while the bidding window was open; sometimes provided unclear guidance to bidders; operated an electronic documents system that failed frequently; and did not notify suppliers when their bid information was incomplete.[31]

In response to those problems, and for other purposes, on July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA), which delayed round 1 and dissolved contracts awarded to winning suppliers.[32] MIPPA postponed competition for round 1 until 2009 and competition for round 2 until 2011. MIPPA excluded Puerto Rico from round 1 of the competition and clarified that round 2 would consist of 70 additional MSAs (for a total of 79).

MIPPA made several other changes to the competitive bidding program. In order to finance the delay in competitive bidding, payments for items subject to competitive bidding were reduced by 9.5% in 2009 relative to 2008 levels. MIPPA required CMS to institute a document review process to enable suppliers to submit paperwork omitted from the initial submission. In addition, MIPPA requires CMS to establish an ombudsman for the competitive bidding program to respond to complaints from beneficiaries and suppliers.[33]

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[30] P. L. 108-173.

[31] Government Accountability Office, 2009 GAO – 10 – 27, “CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program.”

[32] Morgan, P.C., April 28, 2010, Congressional Research Service, “Medicare Durable Medical Equipment: the Competitive Bidding Program.”

[33] Palmetto GBA (competitive bidding implementation contractor), "Fact Sheet about the DMEPOS Competitive Bidding Program Round 1 Rebid: What's New."

Physicians, physical therapists, and others furnishing limited categories of DMEPOS to their patients were excluded in most cases. MIPPA also excluded complex rehabilitative power wheelchairs from the competitive bidding program.

In 2010, the Patient Protection and Affordable Care Act (ACA) mandated that CMS accelerate the adoption of competitive bidding by adding 91 MSAs in the second round (to be conducted in 2011) instead of 70, for a total of 100 MSAs nationwide. ACA also requires CMS to apply rates observed in competitively bid areas to other areas, nationwide, by 2016.[34]

V. RECENT ACTIVITY IN THE COMPETITIVE BIDDING FOR DME PROGRAM

CMS conducted the competition for the round 1 re-bid in 2009. In July 2010, CMS announced the payment amounts for each product category and commenced the contracting process with the initial batch of winning suppliers.[35] (The initial winners may differ from those ultimately holding contracts in cases where the initial winners decline the contract or are later disqualified from the program.) Final contracts and lists of suppliers for each product category in each MSA will be announced in the fall, with a target date of September. Contracts take effect on January 1, 2011, for a period of 3 years. Between announcement of the contract suppliers and commencement of the contract period CMS will engage beneficiaries, providers (including discharge planners), and suppliers, in an education process to explain the new arrangements.[36]

CMS has announced the single price amounts for the 9 MSAs in the Round 1 re-bid. Average price savings across all product categories was 32% for both the federal payment and for beneficiary cost sharing obligations.[37]

For oxygen concentrators, the average monthly payment in competitive bidding areas will be reduced from $173 to $116, a reduction of $46 per month for federal Medicare payments and a reduction of $11.40 for beneficiary cost sharing. Over 3 years (the maximum payment term for

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http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Fact_Sheet_Whats_New.pdf/$FIle/Fact_Sheet_Whats_New.pdf

[34] P. L. 111-148

[35] Centers for Medicare & Medicaid Services, July 1, 2010, "Medicare Fact Sheet: New Program Reduces Costs for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies."

[36] Centers for Medicare & Medicaid Services, Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Round 1 Rebid Bidding Timeline, https://www.cms.gov/DMEPOSCompetitiveBid/01A0_Timeline.asp#TopOfPage

[37] Centers for Medicare & Medicaid Services. July 1, 2010, "Medicare Fact Sheet: New Program Reduces Costs for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies."

oxygen equipment), the Medicare savings for an oxygen concentrator will total $1,642, and the beneficiary cost sharing savings will be $410, on average.

Diabetic testing strips ordered through the mail experienced the largest savings through competitive bidding, while complex power mobility devices experience the smallest, at 56% and 14%, on average, respectively (diabetic testing supplies delivered in the retail setting are excluded from competitive bidding at this time).

Savings for product categories, averaged across the 9 competitively bid MSAs, are as follows[38]:

Product Category	*Percentage reduction in Medicare allowed charge (%)*
Oxygen Supplies & Equipment	31
Standard power mobility devices and accessories	23
Complex power mobility devices and accessories	14
Mail-Order Diabetic Supplies	56
Enteral nutrients, equipment, & supplies	28
Continuous positive airway pressure/respiratory assist device and accessories	34
Hospital beds & accessories	36
Walkers & accessories	33
Support surfaces (Miami only)	49
Overall average	32

Information on savings by product category for each of the 9 Round 1 MSAs is available on the website of the competitive bidding implementation contractor.[39]

[38] Palmetto GBA (competitive bidding implementation contractor). "DMEPOS Competitive Bidding – Round 1 Rebid – Weighted Average Savings." http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Weighted_Average_Savings.pdf/$File/Weighted_Average_Savings.pdf?Open&cat=Suppliers~Information for Contract Suppliers

[39] *Ibid.*

VI. WITNESSES

The following witnesses have been invited to testify:

Panel 1

Laurence Wilson
Director
Chronic Care Policy Group
Center for Medicare & Medicaid Services

The Honorable Daniel Levinson
Inspector General
Office of the Inspector General
U.S. Department of Health and Human Services

Kathleen King
Director
Health Care
U.S. Government Accountability Office

Panel 2

Richard Lerner
President
Allcare Medical

Alfred Chiplin
Managing Attorney
Center for Medicare Advocacy

Nancy Schlichting
President & CEO
Henry Ford Health System

William Scanlon
Health Policy Consultant