Testimony of

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On

Medicare's Competitive Bidding Program for Durable Medical Equipment:

Implications for Quality, Cost and Access

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I am pleased to be here as you review the implementation of the Medicare Durable Medical Equipment Competitive Bidding Program. I am an economist who has been involved in health policy research for 35 years. Until 2004, I was the managing director of Health Care Issues as the US General Accounting Office. I also have been a member of the Medicare Payment Advisory Commission, completing my second term this past May. My views today are my own and do not reflect those of any organization with which I have been affiliated.

Competitive bidding for durable medical equipment (DME) is one step in attempting to make the Medicare program a more efficient purchaser of services for its beneficiaries. There have been longstanding concerns about the level and growth of Medicare spending. Medicare is the third largest component of federal spending currently amounting to approximately $500 billion a year. Furthermore, the rate of growth of Medicare spending, while mirroring other sectors of health care, has consistently exceeded the growth of GDP, inflation, and the beneficiary population[1]. This growth imposes an increasing burden on taxpayers as well as beneficiaries in the form of higher Part B premiums and cost sharing. It has also raised questions about the long-term affordability and sustainability of the program. Before any other consideration of how to address this situation, it is essential to ask whether the program is being as efficient as possible in maintaining access to medically necessary services for its beneficiaries.

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[1] CBO, *The Budget and Economic Outlook*, August 2010; CMS. *Medicare Enrollment: National Trends*, (http://www.cms.gov/MedicareEnRpts/Downloads/HISMI08.pdf)

Efforts to make Medicare a more efficient purchaser have been underway for many years. Beginning in the early 1980s, Medicare payment methods, such as paying reasonable costs or reasonable charges, widely recognized as inflationary, have been replaced. Prospective payment systems have been introduced for providers including hospitals, skilled nursing facilities, home health agencies, etc. along with a fee schedule for physician services. These payment methods have been refined repeatedly over the years with the initiative coming sometimes from the Congress and sometimes from the program itself. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) includes multiple examples of such payment refinements.

The one area that stands out for not having payment methods reformed in a fundamental way is DME. Efforts to refine Medicare DME payment levels administratively have proven cumbersome and unworkable. Competitive bidding offers an alternative which is conceptually sound and appears feasible. As it does involve a significant shift in how Medicare beneficiaries will obtain DME products, there are legitimate concerns about potential disruptions and negative impacts on beneficiaries and providers. Taking steps to minimize such impacts and ameliorate them promptly is essential because the importance of making Medicare a more efficient purchaser can not be ignored.

My testimony today will review: some of the difficulties with attempting to use administered prices for DME; why I believe competitive bidding offers as suitable approach to establishing Medicare DME payment levels; and the need for intensive ongoing oversight to identify any problems that may emerge and the need for the capacity to address such problems in a timely manner.

Experience with Administered Prices Medicare payments for DME are predominately based on fee schedules constructed using submitted charges from the mid-1980s that have subsequently been updated for inflation. The absence of DME payment reform is in the context of a longstanding volume of evidence that Medicare was overpaying for many items of DME. The GAO and the DHHS/OIG repeatedly documented instances where Medicare payments exceeded retail prices that consumers could easily obtain from pharmacies and other suppliers. For example, GAO reported in 2000 that Medicare paid significantly more than the median retail price from a large sample of pharmacies for catheters, eyeglass frames, and lancets[2]. The differences respectively were: 24 percent, 21 percent, and 36 percent.

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[2] US GAO, *Medicare Payments: Use of Revised "Inherent Reasonableness" Process Generally Appropriate,* GAO/HEHS-00-79, July 2000.

Two administrative options are available for dealing with these inefficient prices—reducing the inflation updates and changing the fees for individual items. Modifying the inflation updates to lower prices for all products would reduce some of the excess payments. However, the difference between current Medicare payment and an efficient price that would maintain access may vary considerably across products. Across the board reductions create the risk over the longer term of access problems for selected items and could leave in place significant excess payments for others. For the longer term, it is important to have a means to adjust prices of individual items to efficient levels. Efforts to make such adjustments through an administrative process have been tried and proved too cumbersome to implement effectively.

The process, known as inherent reasonableness, involved the collection of retail price data from samples of suppliers. These data were then to be used to establish a new price through formal rulemaking. The time required for this process resulted in it being only used once to adjust the Medicare fee schedule for blood glucose monitors.[3] In this case, implementing the process took 3 years. While the Balanced Budget Act of 1997 (P.L. 105-33, BBA) modified the required rule making process to expedite fee schedule changes, the burden of collecting sufficient retail price information remained very significant.

Even if this process of collecting retail price information and setting fees had proven to be more manageable to set fees at a point in time, it would be a continuing challenge to keep fees at efficient levels over time. The nature of much technology means that prices and underlying costs are quite dynamic. Prices are highest when a product is first introduced and then decline over time. Initially products may be expensive reflecting the recoupment of development costs and less ability to spread fixed costs due to limited sales volumes. As products take hold and sales increase, prices drop as fixed costs can be spread over a wider base. In addition, economies of scale in production or cost saving production innovations may also be experienced. Competition from newly introduced substitute products can also pressure prices downward. The resulting pattern of prices falling over time for many products means that Medicare would have to devote considerable attention to keeping its payment levels current.

Having enough resources to undertake the ongoing information collection to identify what individual consumers currently pay at retail would not result in a set of efficient prices for the program. There is no single market price. There is instead a set of prices that vary depending on the purchaser. Being able to sell to Medicare beneficiaries may provide some advantages for a provider. There is greater demand for a provider's

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[3] US GAO, ibid.

products given that beneficiaries pay only a fraction of the price. There is more surety of payment compared to some other purchasers. Medicare is also cited frequently as a prompt payer. To the extent, providers value these advantages of selling to Medicare they may be willing to accept a lower price than charged individual retail buyers.

Competitive Bidding as the Alternative Competitive bidding provides an appropriate and feasible to establishing more efficient payment levels. It creates the incentives for providers to supply Medicare with the information needed to set prices as well as be willing to supply products at lower prices. It does involve moving Medicare away from an any-willing provider approach that maximizes beneficiary choice. However, DME is different in that it involves essentially products that are standardized. The same product purchased from different providers will be identical.

One of the GAO studies documenting Medicare overpayments hinted at the potential power of competitive bidding. The study issued in 1997 contrasted Medicare payments for oxygen services to those of the Department of Veterans Affairs (VA).[4] The VA used competitive bidding to select suppliers. It had more rigorous standards for what services must be provided and yet its per-month payment was approximately one half of Medicare's. Similar findings were reported in 2000 where Medicare prices for selected items were 72 to 259 percent higher than the VA's.[5] The conclusion should not be that Medicare can purchase DME in the same manner as the VA or obtain the same price. How beneficiaries in the two programs access services is very different. The comparison is instructive, however, in indicating that Medicare might gain moving away from an any-willing provider approach to a competition among providers for its business.

The power of competitive bidding comes from bidders' interest in increasing their market shares. Being a winner adds to the potential advantages of dealing with the Medicare program as demand by Medicare beneficiaries will be divided among fewer providers. How much can be gained in terms of more efficient prices depends on how competitive bidding is implemented. Implementation is also key to assuring there is no disruption in access to quality services. Equally important, given Medicare's importance as a purchaser, is that the process treat competitors equitably.

Experience to date has both demonstrated some of the potential benefits of competitive bidding for Medicare and provided opportunities to learn about appropriate implementation. The demonstrations in Florida and Texas, authorized by the BBA,

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[4] US GAO, *Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen,* GAO/HEHS-97-120R, May 1997.

[5] US GAO, *Medicare Payments: Use of" Inherent Reasonableness" Process Generally Appropriate,* GAO/HEHS-00-79, July 2000.

resulted in savings of approximately 19 percent.[6] Access to the services was unchanged with one exception being the use of portable oxygen equipment which experienced a 3 percent overall decline and a 12 percent decline among new users. While a number of potential factors may have been associated with the declines, they also highlighted the need for careful monitoring and having the ability to intervene if concerns arise.

Even more significant savings resulted from the two rounds of bidding in 2007 and 2010 as the program of competitive bidding required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA) has been implemented. Contracts awarded in the 2007 round were estimated to reduce payments by 26 percent.[7] The re-bidding in 2010 required by the Medicare Improvements for Patients and Providers Act of 2009 (P.L. 110-275, MIPPA) are estimated to result in even larger reductions of 32 percent.[8]

While a primary reason for introducing competitive bidding is to reduce excessive Medicare prices, it is important also to minimize any resulting disruptions. The program has been structured, as required by the MMA, to preserve beneficiary access to a range of suppliers and to maintain an important role for small businesses in supplying Medicare DME. The program thus strikes a balance between the objectives of beneficiary choice and small business protection and creating stronger incentives for bidders to offer lower prices. Having very limited numbers of suppliers would give bidders the strongest incentive to bid low for fear they would not be awarded a contract. It might generate lower prices in the short term, Allowing for more contracts to be awarded signals to potential bidders that winning a contract may result in less of a gain in market share and they may decide, therefore, to submit somewhat higher bids.

Increasing the number of contracts awarded may result in somewhat higher bids in the short term, but it also serves to make competitive bidding more robust for the longer term. A risk for a large purchaser, like Medicare, is to become too reliant on a limited number of providers. If issues arise with access, quality or the price of services and sufficient alternative provider capacity is not available, it may be difficult to resolve these issues promptly or effectively. Maintaining more providers in an area gives Medicare

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[6] Tommy Thompson, *Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,* Department of Health and Human Services, 2004.

[7] US GAO, *Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program,* GAO-10-27, November 2009.

[8] CMS Office of Media Affairs, "New Program Reduces Costs for Certain Durable Medical Equipment, Orthotics, and Supplies", *Medicare Fact Sheet,* July 1, 2010.

more flexibility to deal with a poorly performing provider. It also increases the odds that future rounds of bidding will have enough competitors to continue to secure significant savings. Given the market for DME, the likelihood of having enough future competitors would be high regardless. Medicare is a large purchaser of DME, but comprises less than one-third of the market.[9] Current suppliers who do not win a Medicare contract will be able to continue to serve other customers. New suppliers are also likely to be able to enter an area for future rounds of bidding as the requirements to become a qualified bidder appear manageable.

The experience of the first round of bidding in 2007 illustrates that minimizing disruption and concerns involves not just the program design, but the implementation on the ground. Concerns were raised about the adequacy of supplier and beneficiary education, the system for submission of bids, the handling of missing information and the disqualification of bidders. A GAO study released in November confirmed that some of these concerns were real.[10] That report also indicated that CMS had made progress in addressing these issues. Continued attention is essential.

Some of the shortcomings identified in the first round of bidding may be the unfortunate, but often common outcome of introducing such a fundamental change. Often when major changes have been made in Medicare, there have been transition periods where some blending of old and new policies coexisted for some time and allowed for a period of learning for providers and beneficiaries. Competitive bidding does not lend itself to such a phased introduction. A blending of policies over a period of time would significantly reduce the incentives for bidders to compete aggressively.

Substantial change requires a learning process on the part of providers and beneficiaries to understand new procedures and rules. It can also involve a need for learning and adaptation on the part of CMS to supply sufficient provider and beneficiary education as well as implement the new procedures and rules appropriately for its part. The approach to phasing specified in the MMA and PPACA involving adding new geographic areas to the program over time does give CMS the opportunity to work more intensively with the first areas and adapt implementation to reflect their experience. Learning should not, however, be allowed simply to be a gradual process. It is important that CMS invest heavily in provider and beneficiary education and in monitoring the process of bidding and contract awards.

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[9] CMS, *Historical National Health Expenditure Data*, http://www1.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

[10] US GAO, op. cit.

Ongoing Oversight Requesting bids, negotiating contracts and securing better prices is only the first phase of making Medicare a more efficient prudent purchaser of DME. Continued oversight to assure that access to and quality of products and services purchased meet expectations is also essential. In both the MMA and MIPAA, the Congress has required GAO to provide a report on experience under the program. Key areas to be examined include: beneficiary access and satisfaction; access or quality issues associated with suppliers new to a geographic or product area; impact on suppliers themselves, especially small businesses, including the costs of participation and the potential for greater efficiencies without affecting access or quality; and changes in the composition of products supplied within each of the Healthcare Common Procedure Coding System (HCPCS) codes.

Asking GAO to provide this report is important, but insufficient. CMS needs to be able to answer these same questions on an ongoing basis. Beneficiaries need clear information about their options for obtaining services and for redress if they incur any difficulties. They need to be informed about to whom to complain and those entities need to be equipped to respond. It is also important that CMS monitor utilization through analyses of claims to be able to detect declines in access or inappropriate substitutions of products. The latter is significant. GAO has noted in several reports on DME that literally hundreds of different items with a wide range of costs are billed under a single HCPC code[11]. Competitive bidding strengthens the incentive to supply lower cost items within a code. It is important for CMS to monitor the provision of items with HCPC codes and to be able to identify whether any substitution that is occurring is appropriate.

A fundamental question to be asked, not just about monitoring utilization of DME but all Medicare services, is whether Medicare has sufficient information about its beneficiaries and the services they receive to assess fully access. Given the investments being made in health information technology, there is an opportunity to improve the information Medicare receives about both the services delivered and the beneficiaries receiving them without a significant increase on the burden to providers. Taking advantage of this opportunity is an important element of making Medicare an efficient purchaser.

Simply identifying problems is not sufficient. CMS must be in a position to resolve them quickly as they arise. As noted previously, increasing the numbers of contractors in an area provides CMS more capacity for addressing a problem. If it proves necessary to suspend or terminate a contract, alternative providers should be available to fill the gap. In addition, CMS needs to do more than deal directly with a poor performing contractor,

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[11] US GAO, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies,* GAO/HEHS-98-102, May 1998, and _____, *Medicare: Past Experience Can Guide Future Competitive Bidding for Medical Equipment and Supplies*, GAO-04-765, September 2004.

informing beneficiaries using that contractor and assisting them in finding an alternative provider is also essential.

Conclusion Making the Medicare program a more efficient purchaser is critical to preserving access for beneficiaries and keeping the program more affordable. Competitive bidding for DME would only involve a small step toward overall program efficiency. But the potential benefits as indicated by the estimated savings of 32 percent from the 2010 bidding are too big to be ignored. Competitive bidding is a conceptually sound approach that fits the circumstances of DME provision and takes advantage of market forces. The introduction of competitive bidding does involve some disruptions and oversight is critical to address any issues arising after implementation. Through the requirements of the MMA to maintain beneficiary choice of providers and protect small business participation, a balance has been struck to reduce those disruptions. CMS can help make the implementation smoother through adequate education of providers and beneficiaries and needs to insure its investment in oversight is sufficient to promptly detect any problems requiring action.