

**STATEMENT OF**

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**ON**

**MEDICARE'S COMPETITIVE BIDDING PROGRAM FOR DURABLE MEDICAL  
EQUIPMENT: IMPLICATIONS FOR QUALITY, COST, AND ACCESS**

**BEFORE THE**

**U.S. HOUSE COMMITTEE ON  
ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH**

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Subcommittee on Health

**Hearing on “Medicare’s Competitive Bidding Program for Durable Medical Equipment:  
Implications for Quality, Cost, and Access”**

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Chairman Pallone, Ranking Member Shimkus, 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 competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), which was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and modified by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Affordable Care Act of 2010. This program was created by Congress to provide greater value to the Medicare program, beneficiaries and taxpayers. When fully implemented, this initiative is expected to reduce beneficiary out-of-pocket costs and ensure their continued access to high quality DMEPOS items and services, bring Medicare’s DMEPOS payments in line with current market pricing, and help combat supplier fraud. In addition, the program is expected to result in billions of dollars of taxpayer and beneficiary savings.

**Overview**

CMS is the largest purchaser of health care in the United States, serving more than 100 million Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. In Fiscal Year 2009, Medicare covered 46.3 million individuals with total program expenditures exceeding \$500 billion. Medicare spent approximately \$8.1 billion on DMEPOS alone in 2009, providing DMEPOS to 10.6 million beneficiaries. Each year, DMEPOS suppliers provide items and services including power wheelchairs, oxygen equipment, walkers and hospital beds to millions of Medicare beneficiaries.

The current Medicare fee-for-service DMEPOS benefit is plagued by an obsolete pricing methodology, grossly inflated prices, and a well-documented proliferation of fraudulent

practices. 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 charge data from approximately 25 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 furnished to non-Medicare customers. Medicare beneficiaries and taxpayers bear the cost of these inflated fee schedule rates. The Administration believes that competitive bidding for DMEPOS will help put an end to Medicare beneficiaries and the Medicare Part B trust fund being overcharged for these items and services. Table 1 shows the difference between the current CMS payment rates for certain DMEPOS items compared to current prices a consumer would see if shopping for that item on the Internet.

**Table 1: Illustrative Comparison Prices Pre-Competitive Bidding**

<i>DMEPOS Items</i>	<i>CMS payment based on fee schedule amount</i>	<i>Illustrative Internet Price<sup>1</sup></i>
Standard power mobility device	\$3,641	\$1,300
Folding walker	\$101	\$40
Continuous positive airway pressure device	\$1,000 <sup>2</sup>	\$399

<sup>1</sup> Prices obtained from Internet on September 3, 2010.

<sup>2</sup> Price is the sum of rental payments for 13 months of use after which the beneficiary takes over ownership of the equipment.

The Department of Health and Human Services’ Office of Inspector General (OIG), the Government Accountability Office (GAO), and other independent analysts have repeatedly highlighted that the current fee schedule prices paid by Medicare for many DMEPOS items are excessive, as much as three or four times the retail prices and amounts paid by commercial insurers or cash customers. These inflated prices in turn increase the amount beneficiaries must pay out-of-pocket for these items. DMEPOS competitive bidding will bring Medicare payments

for DMEPOS more in line with market prices while protecting beneficiaries' access to reputable suppliers.

## **Background**

The DMEPOS competitive bidding program is an essential tool that will help CMS realign Medicare's pricing to pay appropriately for DMEPOS items and services. This tool was proven effective in successful competitive bidding demonstrations in Polk County, Florida and San Antonio, Texas between 1999 and 2002. The demonstrations resulted in 20 percent savings for Medicare and beneficiaries and unchanged access to equipment and quality for beneficiaries. In addition, beneficiaries had overall high satisfaction with the service from these competitive bidding demonstration suppliers. Since the 2002 demonstration, Congress has enacted a number of additional modifications to the DMEPOS competitive bidding program to improve the program and enhance program oversight and monitoring.

The Medicare DMEPOS Competitive Bidding Program was established by the MMA after the conclusion of the successful demonstration projects. Under the MMA, DMEPOS Competitive Bidding Programs were to be phased into Medicare so that competition under the program would occur in 10 metropolitan statistical areas (MSAs) in 2007. Consistent with the statutory mandate, CMS conducted the Round 1 competition in 10 areas and for 10 DMEPOS product categories, and implemented the program on July 1, 2008, for two weeks. The program's single payment amounts resulted in a projected savings of approximately 26 percent compared to the traditional Medicare fee schedule. This indicated the potential for substantial savings for Medicare beneficiaries and taxpayers upon full scale implementation of the program.

On July 15, 2008, MIPPA terminated the Round 1 contracts that were in effect and reinstated fee schedule payment rates; delayed the program; required rebidding of the first round at a later date; and required a 9.5% reduction and no update for Round 1 items for all areas in 2009. MIPPA required competition for Round 2 of the program to be conducted in 2011 in 70 additional MSAs. In addition to the delay, MIPPA mandated certain limited changes but did not change the fundamental nature of the competitive bidding program. For example, MIPPA established a "covered document" review process for providing feedback to suppliers regarding missing

financial documents and a requirement for contract suppliers to disclose their subcontractors to CMS. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for certain providers and suppliers. Finally, MIPPA extended the duration of the Program Advisory and Oversight Committee (PAOC), which advises the Secretary on a number of issues related to implementation of the competitive bidding program. The PAOC includes representatives of beneficiaries, physicians and other practitioners, suppliers, States, organizations that help to establish professional standards, financial standards experts, and representatives from industry associations.

The Affordable Care Act of 2010 expands the number of Round 2 MSAs from 70 to 91 and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016.

The DMEPOS competitive bidding program replaces the existing outdated, excessive fee schedule amounts with market-based prices. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. The new, lower payment amounts resulting from the competition will replace the fee schedule amounts for the bid items in these areas. The payment amounts for the first phase of the program are projected to result in average savings of 32 percent as compared to the current fee schedule prices. These new payment amounts are scheduled to go into effect on January 1, 2011 in nine areas of the country. The program is expected to save more than \$17 billion over ten years (FY2011 – FY2020) as CMS phases in the program as mandated by MIPPA and the Affordable Care Act. In addition to this positive impact on the Medicare Part B trust fund balance, the program is expected to save beneficiaries more than \$11 billion over the next ten years as a result of lower coinsurance payments and lower monthly premium payments. The overall combined savings to Medicare and beneficiaries is therefore expected to total more than \$28 billion over the first ten years of the program -- without compromising quality or access.

It is important to note that savings for the Medicare trust fund, beneficiaries, and taxpayers will not come at the expense of quality items and services or beneficiary access. The DMEPOS competitive bidding program provides important safeguards to ensure participation of only qualified suppliers, continued customer service and access to high quality DMEPOS for beneficiaries, as well as improved oversight protections against fraud. These safeguards are expected to increase the quality of DMEPOS products and services furnished to beneficiaries, while protecting beneficiaries and taxpayers from fraudulent or unscrupulous providers.

The increased oversight and monitoring of DMEPOS suppliers ensures that winning suppliers meet specific quality and financial standards including accreditation of all bidders by an independent accrediting organization. These independent accrediting organizations must examine compliance with business standards and product safety standards, including product-specific service and quality standards. Business standards include how the company is run, how finances and staff performance are managed, how well the company takes care of its consumers, the safety of their products and whether the company's information management systems are in place. Product-specific service standards include intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service. In addition, during the bid selection process, a suppliers' financial health is evaluated through the review of tax and financial documents, and full compliance with appropriate State licensure is also verified. Further, by bringing Medicare prices more in line with the prices of other payers, the competitive bidding program will also make such items and supplies a less profitable target area for fraudsters and bad actors.

### **Implementation of the Round 1 Rebid**

As required by MIPPA, CMS conducted the second Round 1 competition (known as the Round 1 Rebid) in 2009. MIPPA requires that the Round 1 Rebid be conducted in the same areas as the 2008 Round 1 competition, with the exception of Puerto Rico, which was explicitly excluded by MIPPA.

These areas are:

- Charlotte – Gastonia – Concord (North Carolina and South Carolina)
- Cincinnati – Middletown (Ohio, Kentucky and Indiana)
- Cleveland – Elyria – Mentor (Ohio)
- Dallas – Fort Worth – Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami – Fort Lauderdale – Pompano Beach (Florida)
- Orlando – Kissimmee (Florida)
- Pittsburgh (Pennsylvania)
- Riverside – San Bernardino – Ontario (California)

MIPPA designated the items that are included in the Round 1 Rebid. Specifically, MIPPA required CMS to re-compete the same items and services that were bid in the initial Round 1 with certain limited exceptions. Negative pressure wound therapy (NPWT) items and services are excluded from the Round 1 Rebid, but may be included in subsequent rounds. However, Group 3 complex rehabilitative power wheelchairs are excluded from the entire competitive bidding program.

Therefore, the Round 1 Rebid includes the following categories of items and services:

- Oxygen, Oxygen Equipment, and Supplies
- Standard Power Wheelchairs, Scooters, and Related Accessories
- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2 only)
- Mail-Order Diabetic Supplies
- Enteral Nutrients, Equipment and Supplies
- Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices (RADs), and Related Supplies and Accessories
- Hospital Beds and Related Accessories
- Walkers and Related Accessories
- Support Surfaces (Group 2 mattresses and overlays in Miami-Ft.-Lauderdale-Pompano Beach, FL only)

## **Key Operational Improvements**

In implementing the Round 1 Rebid, CMS has incorporated all of the program improvements required by MIPPA. In addition, CMS implemented a number of other important improvements based on our evaluation of the 2008 bidding process, feedback from stakeholders, and advice from the PAOC received through two public meetings and three additional conference calls. Some examples of these key operational improvements include an upgraded bidder education program completed prior to the opening of the bid window, a new and improved online bidding system, an enhanced bid evaluation processes such as a comprehensive upfront licensing verification process, a more rigorous bona fide bid evaluation process, and increased scrutiny of expansion plans for suppliers new to an area or product category.

### *Supplier Communication and Education*

CMS provided many educational tools for the rollout of Round 1, but conducted much of the education concurrent with bidding. Stakeholders and the PAOC gave us feedback that additional education and outreach needed to occur earlier in the process. Consistent with that feedback, CMS began the Round 1 Rebid education campaign in May of 2009 with general “pre-bidding” supplier awareness and education efforts on key steps suppliers were required to take in order to be ready for registration and bidding, including getting appropriate State licenses, updating their Medicare enrollment files with the National Supplier Clearinghouse, and getting accredited and bonded.

After the pre-bidding awareness campaign, CMS launched an intensive bidder education campaign designed to ensure that DMEPOS suppliers interested in bidding had all the information they needed to submit a complete bid in a timely manner. CMS held eight bidders’ conferences, during which all parts of the bidding process were explained to suppliers; these bidders’ conferences were held via teleconference to maximize supplier participation. CMS’ Competitive Bidding Implementation Contractor (CBIC) maintained a dedicated website which included a comprehensive array of important information for suppliers, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC also maintained a toll-free help desk and sent listserv announcements in order to disseminate key information about registration and bidding to suppliers. CMS concluded the

intensive phase of the bidder education campaign before the bid window opened, and continued to offer support to bidding suppliers during the entire bidding period.

### *Online Bidding System*

The online bid submission system used in the original Round 1 had numerous technical issues that caused difficulties for bidders. In response to these issues, before the launch of the Round 1 Rebid, CMS developed a new and improved online system called the DMEPOS Bidding System (DBidS). The DBidS system, which included user-friendly functionality such as a “cut and paste” feature, operated properly throughout the bidding window.

### *Bid Evaluation Process*

CMS instituted a number of critical improvements to the supplier selection process for the Round 1 Rebid. These improvements to the supplier and bid review process will provide additional protection for beneficiaries and help to prevent fraudulent suppliers from receiving contracts.

*Quality Standards:* The MMA required the Secretary to establish quality standards for all DMEPOS suppliers to be applied by independent accreditation organizations but did not set a date by which all suppliers must be accredited. MIPPA clarified that all suppliers must be accredited by October 1, 2009. The DMEPOS quality standards address the set-up and delivery of items and services, beneficiary education on the use of these products, and the accountability, business integrity, and performance management of suppliers. In addition to the general quality standards that all suppliers must meet, there are also product-specific standards for certain items that suppliers must meet in order to furnish these items. For example, suppliers of respiratory equipment such as oxygen equipment, respiratory assistance devices and continuous positive airway pressure devices must comply with specific American Association for Respiratory Care practice guidelines. Another example of product-specific quality standards currently in place is the requirement that every location operated by a supplier of Group 2 complex rehabilitative power wheelchairs employ at least one qualified rehab technology supplier, or be certified as a rehab technology supplier.

As in the initial Round 1, CMS verified bidder accreditation status directly with the accreditation organizations, and only properly accredited suppliers were offered contracts. In the Round 1 Rebid, contract suppliers must also meet MIPPA-mandated requirements to disclose their subcontractors and submit proof of accreditation when applicable. Subcontractors must also meet the same accreditation standards required by principal contract suppliers in order to furnish DMEPOS to Medicare beneficiaries.

*Financial Standards:* The MMA also required that suppliers meet financial standards established by the Secretary in order to contract with Medicare under the competitive bidding program. The competitive bidding regulations established prior to the initial Round 1 require financial standards to be set forth in the request for bids (RFB). These financial standards allow CMS to assess the capability of suppliers to provide quality items and services in sufficient quantities to meet beneficiaries' needs and help screen out fraudulent suppliers with no financial history (e.g., credit or tax history). As part of the bid solicitation process, each supplier submitted required financial documentation, including balance sheets, statements of cash flow, and tax return extracts. CMS evaluated each bidder's financial documentation to determine whether the supplier had met the standards required to participate in the program and to support each bidder's claims of their supply capacity.

In the initial Round 1, suppliers were required to submit three years of financial documents. Based on experience from the initial Round 1, CMS determined that bidders' financial health could be adequately measured through fewer years of documents. Therefore, CMS streamlined the submission requirements for the Round 1 Rebid RFB, to require suppliers to submit one year of financial documents.

*"Covered Document" Review:* In the initial Round 1, many bidders were disqualified because they did not submit all required financial documents specified in the Request for Bids. In response to these concerns, MIPPA required a special document review process for all future rounds of the program. Under this process, suppliers that submit their financial documents by a deadline called the Covered Document Review Date (CDRD) had their documents checked to determine if any financial documents were missing. Bidders that took advantage of this process

were notified of what was missing and were provided an opportunity to submit these documents. MIPPA mandated that this process would apply only to determination of missing financial documents and not to the accuracy or completeness of individual documents. 791 suppliers took advantage of the covered document review process. 321 of the 791 suppliers that submitted a financial document by the CDRD were missing at least one document and were notified of what was missing. All but 14 of the suppliers notified submitted all of the required documentation.

Licensure Review: In the initial Round 1, bidders were required to meet all State licensure requirements prior to submitting a bid. However, there were concerns that some of the 2008 contract suppliers did not have all required licenses. To address this issue for the Round 1 Rebid, CMS instituted a rigorous, comprehensive verification of bidder's compliance with all applicable State licensure requirements early in the bid evaluation process. This involved checking supplier licenses already on file with Medicare, working directly with States to confirm the licensure status of specific bidders, and working directly with suppliers when necessary to verify that they meet the licensure requirements. Further, CMS only offered contracts to suppliers that were properly licensed in each State and for each particular service that the suppliers applied for at the time of their bid application.

Bona Fide Bids: Under the DMEPOS competitive bidding program, only suppliers that submitted bona fide bids can be awarded contracts. Accordingly, all bids submitted under the Round 1 Rebid were screened to ensure that they represent a rational, sustainable, and feasible payment for furnishing the item. In instances where a bid was identified through the bona fide bid screening process as extremely low in relation to other bids, CMS further evaluated that bid to confirm that the supplier could furnish the item at the listed bid amount. In so doing, we reviewed additional information beyond that collected in 2008, such as supplier rationales that support documentation like manufacturer's invoices. During the course of evaluating low bids to ensure that they are bona fide, we obtained numerous invoice prices from current suppliers of these items that are significantly lower than current Medicare fee schedule amounts and internet retail prices. These invoice prices clearly demonstrate that the Medicare fee schedule amounts are excessive and that all bids used in calculating the single payment amounts are bona fide, sustainable, and established in accordance with the goal of the program, which is to establish

reasonable payment amounts for quality items and services under the Medicare program. Only “bona fide” bids were considered for contracts and included in the calculation of the single payment amounts.

Capacity and Expansion Plans: CMS improved its capacity and expansion plan review for the Round 1 Rebid after consultation with the PAOC. The PAOC raised initial concerns that bidders new to an area or product category or reporting high capacity figures might not be able to ramp up to their reported capacity in time to meet the projected demand at the beginning of the contract period.

To address these concerns, CMS utilized a “capacity ramp up” analysis to review what percentage of demand in 2011 would be met by experienced suppliers reporting a modest expansion in capacity and what percentage of demand in 2011 would be met by new suppliers or experienced suppliers reporting more than a modest expansion in capacity. In any case where this second category of suppliers was counted on to meet any portion of projected demand in 2011, the expansion plans of these suppliers were scrutinized with particular emphasis on liquid assets and available credit needed to expand capacity. If a supplier’s expansion plan did not substantiate the supplier’s estimated capacity, CMS adjusted the capacity of the supplier to the supplier’s historic level for the purpose of selecting enough contract suppliers to meet expected demand. Further, in order to ensure appropriate capacity planning and market competition between DMEPOS suppliers in each area, CMS did not allow any one supplier to account for more than 20 percent of the market. Finally, it is important to note that CMS’ projected demand calculations for rented items of DME in 2011 is not discounted in any way to account for the items that will be furnished by non-contract, grandfathered suppliers. In order to ensure sufficient capacity to serve all beneficiary needs, contract supplier capacity was reviewed as if 100 percent of demand must be met by the winning suppliers.

### **Beneficiary Protections**

Consistent with past competitive bidding demonstrations, we fully anticipate that competitive bidding will save money for beneficiaries and taxpayers, while ensuring beneficiary access to

quality items and services. The following are specific examples of the beneficiary protections established in the competitive bidding program:

- Contract suppliers must be accredited and meet applicable licensure requirements and established financial and quality standards. Subcontractors that furnish services under the competitive bidding program must also be identified, meet applicable quality standards, and accreditation requirements. As a result, we will maintain a business model 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 meet these quality standards. For example, all suppliers of oxygen and oxygen equipment are accredited to ensure that they provide respiratory services 24 hours a day, 7 days a week, as needed by the beneficiary.
- 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 based on quality and customer service among winning suppliers will provide beneficiaries with choices regarding their medical equipment and supplies.
- 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 beneficiary-owned equipment from any DMEPOS supplier with a valid Medicare billing number, regardless of whether or not the supplier is a contract supplier.

- Contract suppliers are required to make available to beneficiaries in competitive bidding areas the same items and services that they make available to other Medicare and non-Medicare customers. In other words, contract suppliers cannot discriminate against Medicare beneficiaries and must treat them as they do other individuals needing DMEPOS. For transparency, we will post on our Web site a list of brands furnished by each contract supplier.
- In order to protect beneficiaries from financial liabilities, beneficiaries will not be financially liable when a non-contract supplier furnishes them with a competitively bid item unless they have signed an Advance Beneficiary Notice (ABN).

### **Small Supplier Protections**

While implementing the DMEPOS competitive bidding program, CMS worked closely with suppliers, manufacturers, and beneficiaries through a transparent and open 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 industry representatives and stakeholders. As a result, CMS' policies and implementation of the Round 1 Rebid pay close attention to the concerns of these constituencies, in particular those of small suppliers.

During the implementation of the initial Round 1 of competitive bidding, CMS adopted numerous strategies to ensure small suppliers have the opportunity to be considered for participation in the program. For example:

- CMS worked in coordination with the Small Business Administration (SBA) to develop an appropriate definition of "small supplier" for this program. Under this definition, a small supplier is defined as a supplier that generates gross revenues of \$3.5 million or less in annual receipts, including Medicare and non-Medicare revenue, instead of the SBA's previous standard of \$6.5 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 also allows small suppliers to join together in “networks” in order to meet the requirement to serve the entire competitive bidding area.
- The regulation also established a 30 percent target for small supplier participation in the program.

As a result of CMS’ efforts to give special consideration to small suppliers, 48 percent of the suppliers offered Round 1 Rebid contracts on July 1, 2010 are small suppliers.

### **Round 1 Rebid Results**

As part of the Round 1 Rebid, CMS received 6,215 complete bids from 1,011 suppliers. Utilizing the rigorous review process described above, each bidder and bid was systematically vetted and verified before CMS began offering contracts to these suppliers. On July 1, 2010, CMS made early 1,300 contract offers to 364 suppliers. These suppliers have 622 locations to serve Medicare beneficiaries in the nine competitive bidding areas. 72 percent of these suppliers currently furnish contract items in the area. If any contract offers are not accepted, CMS will offer contracts to other bidders as needed to meet beneficiary demand and anticipated capacity needs.

The single payment amounts for the Round 1 Rebid, which were calculated based on bids submitted by suppliers, were announced on July 1, 2010. As a result of the competitive bidding process, the amounts that Medicare will pay for the nine product categories included in the Round 1 Rebid are 32 percent less on average than Medicare’s current fee schedule amounts. In addition to lower Medicare payments, this directly translates to reduced beneficiary out-of-pocket expenses for certain medical equipment and supplies. The following are examples of savings for three commonly used items: an oxygen concentrator; a semi-electric hospital bed; and a typical monthly supply of 100 diabetic test strips and 100 lancets.

**Table 2: Illustrative Comparison Prices Post-Competitive Bidding**

Item/Period of Service	Current Fee Schedule Allowed Amount**	New Single Payment Amount, under Competitive Bidding**	Medicare Savings 80% of Difference	Beneficiary Copayment Savings 20% of Difference***	Total Savings
<b>Concentrator</b>					
Per month	\$173.17	\$116.16	\$45.61	\$11.40	-32.9%
Per year	\$2,078.04	\$1,393.95	\$547.27	\$136.82	-32.9%
Per 3 years	\$6,234.12	\$4,181.84	\$1,641.82	\$410.46	-32.9%
<b>Hospital Bed</b>					
Per month	\$127.12	\$80.35	\$37.42	\$9.35	-36.7%
Per 13 months*	\$1,334.76	\$843.63	\$392.91	\$98.23	-36.8%
<b>Diabetic Supplies</b>					
Per month	\$75.32	\$33.44	\$33.51	\$8.38	-55.6%
Per year	\$903.87	\$401.24	\$402.10	\$100.53	-55.6%
Per 3 years	\$2,711.60	\$1,203.72	\$1,206.30	\$301.58	-55.6%
<p>* Beneficiary takes over ownership of equipment after end of rental payment period.</p> <p>** 20% of current fee schedule and new allowed amount is paid by the beneficiary out-of-pocket, after they have reached their Part B deductible.</p> <p>***Beneficiaries will also benefit from lower Medicare Part B premiums in addition to copayment savings.</p>					

CMS is currently in the process of finalizing contracts with participating suppliers, and hopes to announce the contract suppliers in the coming weeks. CMS will send letters to all suppliers that have not been offered contracts explaining why they were not awarded a contract and give them an opportunity to ask questions and express concerns. The contract suppliers will begin furnishing beneficiaries with DMEPOS at the single payment amount on January 1, 2011.

CMS continues to analyze the impact of the competitive bidding program on suppliers that may not become contract suppliers. As context, although a large number of DMEPOS suppliers are enrolled in Medicare to furnish DMEPOS items, only about 20 percent of the suppliers in the nine Round 1 Rebid areas conduct a significant amount of Medicare business (e.g., had more

than \$10,000 in allowed charges in 2009), and only 11 percent of suppliers in the nine Round 1 Rebid areas submitted more than \$50,000 in allowed charges in 2009.

In many cases, suppliers that are not offered a contract will still be able to provide certain services to beneficiaries by subcontracting with an approved contract supplier or may become grandfathered suppliers that continue to furnish oxygen and oxygen equipment or rented durable medical equipment to their current customers. Most suppliers elected to continue as grandfathered suppliers under the demonstrations, and approximately 90 percent of suppliers planned to continue furnishing oxygen and oxygen equipment as grandfathered suppliers under the initial Round 1 in 2008. Based on this experience, we expect a high percentage of suppliers will elect to become grandfathered suppliers and continue serving their current patients.

### **Outreach and Education**

Outreach and education of beneficiaries and stakeholders is a key priority for CMS as we prepare to implement the DMEPOS competitive bidding program on January 1, 2011. A comprehensive outreach and education plan is under development to educate beneficiaries, beneficiary partners, providers, stakeholders and contract suppliers. CMS is committed to ensuring that all beneficiaries have the information they need in a timely manner to maintain access to necessary products and services. The primary goal of this education campaign will be to keep beneficiaries, caregivers, referral agents (e.g., hospital discharge planners and physicians), and other stakeholders informed about the new program and how it affects them. Outreach to beneficiaries will include fact sheets, brochures and booklets, Frequently Asked Questions and other postings on medicare.gov, newsletters, an update to the annual *Medicare & You Handbook*, emails, and letters. In addition, our 1-800-MEDICARE customer service representatives and direct service caseworkers are being trained and educated so they are better able to assist beneficiaries who may come to them with questions about the program.

CMS will work with providers of health care services, established networks of providers, and beneficiary advocacy organization partners to keep beneficiaries informed. Outreach to physicians, social workers, referral agents, discharge planners and others will be delivered through the various listservs, and through the Medicare Learning Network (MLN), via MLN Matters articles, fact sheets, brochures, and national provider calls. Educational materials for

medical professionals will be available on the cms.gov website and are also communicated through national and state/local provider associations covering all provider types, as well as through the Medicare fee-for-service contractors via their websites, listservs, bulletins and educational seminars. Local outreach in the nine competitively bid areas (CBA) is already underway to educate health care providers, particularly those who refer beneficiaries to suppliers of the DMEPOS items included in the program.

CMS also plans a special education program for contract suppliers to ensure that they understand all of their obligations. Contract supplier educational materials will be posted on the CBIC website and will include fact sheets, FAQs, and other materials. CMS will hold educational sessions for contract suppliers via teleconference and transmit key information via listservs.

### **Program Oversight and Monitoring**

In order to ensure that beneficiaries' DMEPOS needs are satisfactorily met, CMS will be proactively monitoring the implementation of the competitive bidding program through numerous methods.

#### *Beneficiary Surveys*

We will be actively seeking feedback from beneficiaries through consumer satisfaction surveys conducted before and after the rollout of the program. These surveys will provide direct insight into how the program is affecting beneficiaries. In addition to these surveys, 1-800-MEDICARE is prepared to field questions and concerns from beneficiaries. CMS is committed to quickly addressing all comments and concerns from beneficiaries and will work with our regional offices to respond, and investigate when appropriate, as quickly as possible.

#### *Competitive Acquisition Ombudsman*

As required by MIPPA, CMS appointed an Acting Competitive Acquisition Ombudsman (CAO) in July 2009 to respond to inquiries and complaints from suppliers and individuals regarding the application of the program. The CAO's core functions include: ensuring appropriate processes for handling supplier and beneficiary complaints and inquiries; an annual report to Congress; identifying potential issues and developing risk mitigation strategies with CMS, and

communicating identified concerns of beneficiaries and suppliers to CMS. The CAO will begin to hear complaints after contract suppliers are announced.

To date, the CAO has established Ombudsman operations and business processes and has been meeting with key stakeholders, such as the PAOC, disability advocates, and partners to identify potential issues. The CAO will play an important role during the implementation of the competitive bidding program by assisting suppliers and beneficiaries with their complaints, reporting on potential service and quality concerns, and working with the Agency and partners to respond to these complaints and concerns.

#### *Complaint Process*

When competitive bidding is implemented in 2011, there will also be a formal complaint process for beneficiaries, caregivers, providers and suppliers to use for reporting concerns about contract supplier or other competitive bidding implementation issues. This process is designed to ensure that all complaints are correctly routed, investigated, resolved, tracked and reported.

#### *Quarterly Report*

Contract suppliers will be required, as a term of their contract, to fill out a quarterly report on the specific brands of items they furnish to Medicare beneficiaries. The information on this report will be used to update the supplier locator tool on the medicare.gov website so that beneficiaries and caregivers are able to easily identify contract suppliers that offer the brands they need. This quarterly report will also help CMS evaluate supplier compliance with the non-discrimination contract requirement, which requires contract suppliers to make the same items available to Medicare and non-Medicare customers.

#### *Local Outreach*

The CMS regional offices and local CBIC ombudsmen will provide on-the-ground presence in each competitive bidding area. They will closely monitor transition activities, conduct environmental scanning, analyze trends, and identify and address any emerging issues. These efforts will inform the agency on potential issues, vulnerabilities and readiness for effective and credible management of the program.

### *Claims Analysis*

Claims analysis is the final piece of our comprehensive oversight and monitoring plan. Through more sophisticated claims analysis, CMS will be able to identify utilization trends, monitor beneficiary access, address aberrancies in services, and target potential fraud and abuse.

### **Future Rounds of DMEPOS Competitive Bidding**

CMS has shared its preliminary timeline for phase-in of Round 2 of the program with the PAOC and expects contracts and payment amounts for this Round to take effect on January 1, 2013, following the competition which is mandated to occur in 2011 in accordance with MIPPA. Due to changes authorized by the Affordable Care Act, Round 2 of competitive bidding will expand the program to include 91 additional MSAs, bringing the total competitive bidding MSAs to 100. National mail order for diabetic testing supplies can also be implemented after 2010. CMS has recently published a proposed rule (CMS-1503-P) on the implementation of the national mail order program as well as policies affecting Round 2. The rule is expected to be finalized later this year in order to meet the requirements of the statute to phase-in the Round 2 competition in 2011 and any competitions for national mail order items and services after 2010.

### **Conclusion**

Past experience has shown that competitive bidding of DMEPOS products and services can provide savings, value, and benefits to both beneficiaries and the Medicare program, while ensuring delivery of quality items and services. CMS understands the concerns of Congress and stakeholders, and in the Round 1 Rebid, has taken care to improve and implement the program in a way that emphasizes the needs of beneficiaries while addressing the concerns of suppliers. In the coming months, CMS will continue to implement the DMEPOS Round 1 Rebid and future competitive bidding program rounds in an open and orderly way.