

The Risks to Medicare Beneficiaries of DMEPOS Competitive Bidding – Considerations for the Round 1 Re-Bid and Beyond

*Are Choice, Access, and Quality for Medicare's Most
Vulnerable Being Compromised?*

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Are Choice, Access, and Quality for Medicare's Most Vulnerable Being Compromised?

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Executive Summary

Purpose: To examine the potential impact of the Centers for Medicare & Medicaid Services (CMS) competitive bidding (CB) program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) on Medicare beneficiary choice, access, and quality.

Methods: A literature review (including government reports, congressional testimony, journal articles, and news media), as well as interviews with patient advocates, beneficiaries, discharge planners, independent academic experts, suppliers, and former CMS contractors and officials.

Summary: The CB program's emphasis on price competition may result in unsustainable price reductions, eroding supplier competition based on quality service and equipment, and producing a range of unintended consequences. This could result in Medicare's most vulnerable beneficiaries experiencing medical complications, increasing their use of hospital, emergency room, and physician care, and losing their ability to live independently.

Marketplace Implications: The design of the CB program creates economic incentives that could produce unsustainably low prices and lead to reduced quality and service for Medicare beneficiaries.

- The three-year bid period, the composite price structure used to calculate prices, a flawed coding system, and both "predatory" and "suicide" bidding could produce unrealistically low bid prices incompatible with sustained service and product quality.
- Fewer suppliers could lead to less, not more, price competition over the long term.
- The CB program design is highly susceptible to "gaming," allowing sophisticated bidders to use complex rules and the volatility of supply and demand to their advantage.

Choice: Freedom of choice will be challenged for beneficiaries both in terms of types of suppliers and types of equipment that will be available.

- The CB program could eliminate up to 90 percent of DMEPOS suppliers, limiting choice of preferred providers and disrupting long-term relationships and continuity of care for patients.

Access: As the number of suppliers is reduced, beneficiaries could experience problems accessing quality equipment and services, especially by geographic area and over time.

- Lower payments to suppliers may reduce beneficiary access to high quality, brand name, and customizable equipment, and other effective supplies that are familiar to the patient.
- The CB program may not adequately protect against supplier unavailability and delayed response time, causing hospital discharge delays and/or more emergency department visits.
- The CB program may reduce the provision of various services on which beneficiaries rely to remain independent and prevent complications, such as patient evaluation, education, and training, and equipment customization, adjustment, and timely repair and maintenance.

Quality: Under dramatically lowered prices, suppliers may not be able to provide high quality products, and may significantly reduce the services they provide to beneficiaries.

- Suppliers may not be able to afford (and are not incentivized to provide) higher quality products, which can affect beneficiary mobility, general health condition, and quality of life.
- Technological innovation and development of high quality products may be stifled.

Introduction

On January 1, 2011, the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will go into effect in nine of the largest metropolitan statistical areas (MSAs) in the United States. DMEPOS include hospital beds, wheelchairs, oxygen concentrators, pacemakers, prosthetic limbs, and many other types of medically necessary equipment or supplies that can be used in the home. Beneficiaries using DMEPOS are typically elderly and/or disabled, often have multiple co-morbidities and impaired mobility, and represent a particularly vulnerable segment of the Medicare population.

The competitive bidding program represents a change from Medicare’s long-standing policy that any qualified provider can participate in the program.

While the competitive bidding program is intended to reduce costs, it also “represents a change from Medicare’s long-standing policy that any qualified provider can participate in Medicare.”¹ Unlike the competitive acquisition programs under Medicare Advantage and Medicare Part D, the DMEPOS competitive bidding program lacks basic safety and other consumer safeguards that have become staples of the modern, market-based competitive purchasing arrangements (e.g. marketing and information requirements, evidence-based standards for the quality and safety of manufacturer items, and supplier services).² Thus, the competitive bidding program radically alters the payment system currently used by the Centers for Medicare and Medicaid Services (CMS) and Medicare beneficiaries to purchase DMEPOS, and may result in a series of unintended consequences for beneficiaries in terms of reductions in choice, access, and quality.

The competitive bidding program, with its emphasis on price, will likely limit competition based on service for DMEPOS products and result in less quality and service for Medicare beneficiaries, as occurred in the airline industry. While the two most important consequences of deregulation in the airline industry have been lower fares and higher

¹ King, K. (2009). Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program. GAO-10-27. Washington, DC: November 6.

² Rosenbaum, S., Dor, A., Finnegan, B., Jones, E. (2008). Medicare competitive acquisition: Implications for persons with diabetes. *The George Washington University School of Public Health and Health Services, Department of Health Policy.*

Introduction

productivity, those gains have come at a cost. Quality of air travel has been noticeably reduced in the form of increased congestion, delays, and discomfort. Aggressive low-cost carriers provided fewer services, narrower seating, and longer lines; existing companies responded by similar price cuts followed by comparable cuts in service.³ In addition to quality issues, the competitive bidding program may ultimately thwart price competition if the number of suppliers in the DMEPOS marketplace is restricted over the long term.

Dobson DaVanzo & Associates, LLC was commissioned by AAHomecare to examine the impact the DMEPOS competitive bidding program could have on Medicare's most vulnerable beneficiaries. Along with a literature review (including government reports, congressional testimony, journal articles, and news media), we conducted a series of key stakeholder interviews with hospital discharge planners, patient advocates, Medicare beneficiaries, independent academic experts, DMEPOS suppliers, CMS contractors who designed the DMEPOS demonstration project, and a former CMS official.

This report starts with a description of DMEPOS products and the Medicare beneficiaries that use DMEPOS, followed by a background section on the competitive bidding program. The next section describes a series of flaws in the design of the competitive bidding process and its anticipated impact on the DMEPOS marketplace. The report then presents a range of potential unintended consequences that beneficiaries could experience, based on observations from the demonstration projects, operation of Round 1 winners and prices (two week duration), concerns raised during interviews with key stakeholders, and anecdotal evidence from the preliminary results of the current Round 1 Re-bid.

³ Alfred E. Kahn. "Airline Deregulation." *The Concise Encyclopedia of Economics*. 1993. Library of Economics and Liberty. Retrieved July 26, 2010 from: <http://www.econlib.org/library/Enc1/AirlineDeregulation.html>

Background

DMEPOS Products

DMEPOS can be classified into three types of products. Durable medical equipment (DME) is equipment that serves a medical purpose, can withstand repeated use, is generally not useful in the absence of illness or injury, and is appropriate for use in the home. Common products include hospital beds, wheelchairs, and oxygen concentrators. DME also includes any associated drugs or biologics that accompany the medical equipment, such as diabetic testing strips. Prosthetic and orthotic devices (PO) are items that replace all or part of an internal body organ, such as pacemakers and prosthetic limbs. Supplies (S) are items covered by Medicare that do not meet the definitions of DME or PO, such as disposable surgical dressings.⁴ Spending on DMEPOS accounted for approximately two percent of total Medicare spending in 1999 and 2009.⁵

Medicare beneficiaries that use DMEPOS often have disabilities and long-term, chronic conditions – representing one of Medicare’s most vulnerable patient populations.

Beneficiaries Who Use DMEPOS

There are two main types of Medicare beneficiaries who use DMEPOS: 1) patients discharged from the hospital with temporary needs for rehabilitation; and 2) patients with long-term, chronic conditions that often deteriorate over time. Patients with long-term, chronic conditions – including cerebral palsy, neuromuscular disorders such as multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes – often have multiple co-morbidities, have issues with mobility, and are in need of several different types of DMEPOS products. Unless these beneficiaries experience an acute hospital episode, discharge planners are not typically involved in their care and do not assist them in obtaining DMEPOS. Instead, they rely heavily on direct

⁴ Morgan, P.C. (2010). Medicare durable medical equipment: The competitive bidding program. *Congressional Research Service*. Washington, D.C. April 28.

⁵ Medicare Payment Advisory Commission (2010). A data book: Healthcare spending and the Medicare program. [Chart 1-9]. Washington, DC: MedPAC.

relationships with their suppliers. As these patient relationships develop over many years, suppliers become more knowledgeable about their patient's condition and familiar with their preferences for equipment and supplies. In the absence of a cure, clinically appropriate and properly fitted DMEPOS is often the best and most cost-effective medical intervention for these beneficiaries and preserves their ability to live independently.

The DMEPOS Competitive Bidding Program

Medicare has paid for DMEPOS products by using a fee schedule determined through administered reference pricing established in 1989. The fee schedule was originally set at the average amount DMEPOS suppliers charged Medicare in 1986 and 1987, adjusted geographically by state, and updated for inflation annually using the urban consumer price index (CPI-U).

In order to reduce prices paid by the Medicare program for DMEPOS, Congress passed legislation that required CMS to implement a competitive bidding program for DMEPOS suppliers. The Balanced Budget Act of 1997 (BBA) authorized CMS to conduct a competitive bidding demonstration. Three demonstration projects were conducted between 1999 and 2002: two rounds in Polk County, Florida and one round in San Antonio, Texas. Several quality and access to care issues were observed during the demonstration,⁶ and no analysis of the competitive bidding program's long-term effects on market competition was ever conducted.⁷ The Medicare Modernization Act of 2003 (MMA) mandated that CMS establish a permanent competitive bidding program. Round 1 of the program was implemented in 10 MSAs in 2007; winning suppliers and bid prices took effect in these MSAs on July 1, 2008.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) – which Congress committed to passing over a presidential veto – terminated Round 1 two weeks after bid prices took effect. MIPPA called for changes to the program, and required CMS to re-bid supplies for Round 1 amid a number of stakeholders concerns. CMS attempted to address these concerns through the Round 1 Re-bid, which will go into effect on January 1, 2011. Despite CMS's attempt to address issues that arose during the Round 1 bidding process, a number of concerns with the program remain. These unresolved issues could have significant implications for an estimated 2.7 million DMEPOS-eligible Medicare beneficiaries.⁸

⁶ For example, the proportion of new oxygen users in Polk County, Florida receiving portable oxygen decreased by 24 percent, and the complaint rates and reports of "no help" from beneficiaries rose considerably in San Antonio, Texas. See: Thompson, T. (2004). 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*. Washington, D.C.

⁷ Thompson, T. (2004). 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*. Washington, D.C.

⁸ According to CMS, there were an estimated 2.7 million eligible beneficiaries in 2005 living in the nine competitive bidding areas (CBAs) included in the Round 1 Re-bid. (Note: San Juan, Puerto Rico was one of the original Round 1 CBAs, but was excluded from the Round 1 Re-bid and is therefore not included in our population estimate). Centers for Medicare and Medicaid Services (2007, April 2). *New program reduces costs and improves access to high quality medical equipment and supplies for Medicare beneficiaries*. [Press release]. Retrieved from: https://list.nih.gov/cgi-bin/wa.exe?A2=ind0704&L=HHS_CMS_PRESS&F=&S=&P=2189

Market-Based Flaws in the Competitive Bidding Program

Design Flaws

There are several problems inherent in CMS's design of the competitive bidding process that create perverse incentives and may result in unsustainable low bids from suppliers. Furthermore, the competitive bidding program design does not provide beneficiaries with adequate protections against degradation in care or service.

LENGTH OF BID PERIOD

The length of time between bid periods – three years – raises several issues for accuracy in reimbursement and supplier behavior. Two academic researchers that were interviewed noted that the three year time between re-bid periods locks suppliers into a fixed price arrangement, which does not accurately reflect either changing prices or demand in a volatile market. One former CMS contractor who assisted in evaluating the DMEPOS demonstration project indicated that the length of time between bid periods is a trade-off between administrative cost savings and accuracy in market pricing, and that longer periods could lead to less innovation and choice of products.

Furthermore, a fixed-price period of three years does not account for new financial pressures that will be placed on DMEPOS suppliers in a number of ways. Demand for DMEPOS products will change both as eligibility for Medicare changes under health care reform and as the population ages. In addition, other commercial and public payers that use Medicare prices as a benchmark may reduce the prices they will pay for DMEPOS as well. Anecdotal evidence suggests that several state Medicaid programs have already begun to reevaluate their fee schedules based on the Round 1 Re-bid savings estimates.

CALCULATION OF BID PRICE

The method used to calculate the bid price for each item creates opportunities for “gaming” the system and produces other negative consequences. As bidders are not held to the bid

The length of the bid period, the method used to calculate the price, and the unrecognized complexity of the DMEPOS business will cause disruption in the marketplace.

Market-Based Flaws in the Competitive Bidding Program

price they submit, calculating a price based on the median winning bid allows speculation with the expectation that prices will be pulled up by winners with higher bids. A former CMS official noted that the system does not hold suppliers accountable for submitting irrational bids, and allows for suppliers to speculatively bid as a plan for business development. In addition, one supplier observed that the bid prices of the winners who do not accept the bid price are not removed from the final price calculation, which causes bid winners to be affected by the low bids of speculators.

Using the median bid price, half of the initial bid winners will be offered a price below their actual bid. This method differs significantly from the demonstration project, in which the bid price was determined by the “pivotal bid” – the bid that identified when the capacity of the bid winners was large enough to meet beneficiary demand – and all winning bidders received a price at or above the initial offer.⁹ Although this change could potentially reduce irrational bidding, a former CMS contractor disagreed with the decision to change how the bid price is calculated because it could cause bidders that are offered a price below their bid to refuse the contract.

The method used by CMS to determine relative weights for each item within a category, based on demand determined from DMEPOS claims in calendar year 2006,¹⁰ does not account for volatility in the DMEPOS market across several years. This calculation also allows sophisticated bidders to bid higher on large volume items and lower on small volume items while maintaining a low overall composite bid.¹¹

SUICIDE BIDDING

The competitive bidding program incentivizes small businesses to submit “suicide bids” in order to survive in the marketplace, although these companies may not be able to sustain their business over the long-term at such low prices. Anecdotal evidence from interviews with DMEPOS suppliers, and patient advocates who work closely with suppliers, indicated that many small businesses submitted unrealistically low bids out of fear they would be forced to close, and are now concerned about how to operate given the new prices. Although CMS announced it was comfortable with the bid prices submitted overall, the Director of the Chronic Care Policy Group at CMS said during a media phone call that

⁹ In the competitive bidding program, bids were ranked by composite price from lowest to highest. The pivotal bid was identified as the bid where cumulative projected capacity to serve beneficiaries for a given product met or exceeded CMS’s estimated beneficiary demand, in turn becoming the highest bid price awarded. During the demonstration project, the pivotal bid was used to set the price for each product category, whereas in Round 1 and the Round 1 Re-bid, the price for each product category was calculated as the median between the lowest bid and the pivotal bid. For a more detailed discussion, see: King, K. (2009). Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program. GAO-10-27. Washington, DC: November 6.

¹⁰ King, K. (2009). Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program. GAO-10-27. Washington, DC: November 6.

¹¹ Katzman, B., McGeary, K.A. (2008). Will competitive bidding decrease Medicare prices? *Southern Economics Journal*, 74(3), 839-856.

Market-Based Flaws in the Competitive Bidding Program

CMS was uncomfortable with a supplier's stated ability to serve patients *30 percent of the time*. This caused CMS to disregard a bidder's stated capacity to serve beneficiaries.¹²

The Department of Health and Human Services' (DHHS) *Final Report to Congress* in 2004 on the demonstration evaluation predicted this very outcome: "inexperienced bidders may bid too aggressively low at the outset."¹³ A financial analyst with the Susquehanna Financial Group recently echoed these sentiments as well:

"The bid structure incentivizes the small provider to bid very aggressively... They didn't have to stand by their rate if they did not like the [new CMS] rate. They are not held to providing the service at what they bid."¹⁴

The analyst went on to question whether or not suppliers would be able to meet the new bid prices without negatively affecting beneficiaries, and said, "With all the cuts that have come before, this seems very draconian to me."¹⁵

An independent academic and expert on competitive bidding noted that these small companies are not submitting bids in order to set the bid price, but rather submitting bids to survive. Ultimately, many companies believed that these prices are not sustainable: in a poll of nearly 400 DMEPOS providers taken in August 2010, over 80 percent of respondents said the bid prices were too low to accept. Those companies that won and accepted a bid indicated they would meet new prices by cutting services and providing less expensive, low quality equipment.¹⁶

From the perspective of large companies, it is also possible that "predatory pricing" could be used to force out local competition. This tactic was used by Blockbuster Inc. in the video rental industry, for example. If employed by large DMEPOS suppliers, predatory pricing will reduce long run competition by smaller suppliers that cannot maintain operations without Medicare business before the next bid period opens.

The competitive bidding program does not distinguish between large and small DMEPOS suppliers, at the national or local level. A former CMS official noted that organized markets are more complex than CMS assumes, and that the competitive bidding program does not understand the difference between national and small local providers on a market by market basis.

¹² Beaulieu, L. (2010, July 2). CMS: 'We're comfortable, when we look at the prices we see.' *HME News*. Retrieved from: <http://www.hmenews.com/?p=article&id=hm2010078jopzV>

¹³ Thompson, T. (2004). 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*. Washington, D.C.

¹⁴ HomeCare (2010, July 16). Rotech, Lincare and competitive bidding: How will it all play out? Retrieved from: <http://homecaremag.com/topics/competitive-bidding/rotech-lincare-competitive-bidding-20100715/>

¹⁵ HomeCare (2010, July 16). Rotech, Lincare and competitive bidding: How will it all play out? Retrieved from: <http://homecaremag.com/topics/competitive-bidding/rotech-lincare-competitive-bidding-20100715/>

¹⁶ Flaherty, F. (2010, July 16). Competitive bidding: If offered contracts, most providers would just say 'no.' *HME News*. Retrieved from: <http://www.hmenews.com/?p=article&id=hm201007vNHvSS>

Market-Based Flaws in the Competitive Bidding Program

In Round 1 of the Polk County, Florida demonstration project, the bid winners were mainly local suppliers, evenly divided between small and large market share. Three out of the four national DMEPOS companies with market share in Polk County either did not bid or were not selected for the demonstration. Two of the Round 1 bid winners were acquired by a large national DMEPOS supplier with previous presence in Polk County during the first round. And in Round 2, three out of the eight new bid winners were either out of town or out of state.¹⁷ The Polk County, Florida demonstration shows a trend over time whereby large DMEPOS suppliers, present in several markets, increased their participation in the competitive bidding program through bidding and acquisition. There is already evidence of this trend in the Round 1 Re-bid: a DMEPOS industry-watcher reported in July 2010 that the national DMEPOS supplier Lincare had finalized an agreement to purchase one bid winner and speculated there would be additional future acquisitions.¹⁸

One former CMS contractor commented that DMEPOS suppliers will be able to sustain losing the bid contract or accepting significant reductions in price by maintaining Medicare margins outside of the competitive bidding areas. However, this will not be possible for small, local providers that only have market presence in a competitive bidding area. Invacare, a large DMEPOS manufacturer, said in its annual report that, “Reductions in reimbursement levels also may affect the profitability of the company’s customers and ultimately force some customers without strong financial resources to go out of business...some of the company’s customers may not be able to adapt quickly enough to survive.”¹⁹

The design of the competitive bidding program, and the cost savings it is predicted to achieve, does not adequately consider the negative impact such reductions in reimbursement will have on small DMEPOS suppliers.

PROTECTIONS FOR BENEFICIARIES

The coding system used by CMS is flawed and could compromise the availability of specialized, high quality products. The coding system groups products and devices into the same category together that are of substantially different quality. These higher quality products – and the services that accompany them – will not be appropriately reimbursed if paid at the same rate. A report by the George Washington University School of Public Health and Health Services argues that an incomplete coding system has the tendency to mask suppliers’ dangerous narrowing of beneficiary access to products, “fostering

¹⁷ Meadow, A., Karon, S., Hoerger, T., Bernard, S., Tate, K., Lindrooth, R., Waters, T., Jewell, K. (2003). Evaluation of Medicare’s competitive bidding demonstration for DMEPOS. Funded by the Centers for Medicare & Medicaid Services under Contract No. 500-95-0061. RTI International (Research Triangle Park, NC).

¹⁸ HomeCare (2010, July 16). Rotech, Lincare and competitive bidding: How will it all play out? Retrieved from: <http://homecaremag.com/topics/competitive-bidding/rotech-lincare-competitive-bidding-20100715/>

¹⁹ Invacare Corporation (2009). 2009 Annual Report and Form 10-K. pp. 24, Retrieved from <http://www.invacare.com/HQ/EDITORIAL/20100401/2009%20Form%2010-K%20and%20Annual%20Report.pdf>

Market-Based Flaws in the Competitive Bidding Program

wholesale product substitution even when clinical customization may be essential.”²⁰ The competitive bidding program will exacerbate these limitations of the coding system and potentially harm beneficiaries in need of high quality equipment.

CMS also did not put into place adequate protections for beneficiaries that ensure bid winners will be able to meet their stated capacity. CMS did not independently assess the capacity of suppliers to provide services, and did not release methodology used to assess financial viability standards. For example, Rotech Healthcare announced that it won 17 competitive bidding contracts, but as of June 30, 2010 has approximately \$513.2 million in outstanding long-term debt. Rotech was considering restructuring or filing for bankruptcy, and expects to lose up to \$900,000 in the first quarter of 2011.^{21,22}

Several provisions in MIPPA, such as accreditation and licensure, were aimed at addressing the lack of quality standards in Round 1. However, while the accreditation and licensure processes are necessary, they do not ensure beneficiary safeguards against a reduction in the quality of supplier products or services that may result from an emphasis on price competition, as happened in the airline industry.²³

The consequences of a complex competitive bidding system, from a game theory perspective, are unpredictable. The entire CMS competitive bidding process distorts marketplace dynamics and may or may not be beneficial to Medicare beneficiaries over either the short or long term.

²⁰ Rosenbaum, S., Dor, A., Finnegan, B., Jones, E. (2008). Medicare competitive acquisition: Implications for persons with diabetes. *The George Washington University School of Public Health and Health Services, Department of Health Policy*.

²¹ MarketWatch (2010, August 4). Rotech Healthcare reports second quarter and first half 2010 financial results. Retrieved from: http://www.marketwatch.com/story/rotech-healthcare-reports-second-quarter-and-first-half-2010-financial-results-2010-08-04?reflink=MW_news_stmp

²² HomeCare (2010, July 16). Rotech, Lincare and competitive bidding: How will it all play out? Retrieved from: <http://homecaremag.com/topics/competitive-bidding/rotech-lincare-competitive-bidding-20100715/>

²³ Alfred E. Kahn. "Airline Deregulation." *The Concise Encyclopedia of Economics*. 1993. Library of Economics and Liberty. Retrieved July 26, 2010 from: <http://www.econlib.org/library/Enc1/AirlineDeregulation.html>

Potential Impact on Beneficiaries

Medicare beneficiaries may experience a range of challenges in obtaining DMEPOS products and assistive services after competitive bidding prices go into effect. These challenges could prove difficult to quantify, because unlike the demonstration project, neither the legislation passed by Congress, nor the regulations implemented by CMS, contain a provision to measure the impact on beneficiaries through pre- and post-implementation surveys.

Choice

Freedom of choice will be reduced for beneficiaries in terms of both suppliers and products.

CHOICE OF SUPPLIER

Up to 90 percent of current DMEPOS suppliers could be eliminated from the Medicare program across all competitive bidding areas included in the program.²⁴ If their current supplier is eliminated in the bidding process and does not decide to grandfather current patients at the new competitively bid prices, beneficiaries cannot choose to remain with their preferred supplier.

Patient advocates that were interviewed agreed that long-term relationships with providers and continuity of care are extremely important to beneficiaries with chronic conditions and severe disabilities. Unless these beneficiaries experience an acute hospital episode, discharge planners are not typically involved in their care and do not assist them in obtaining DMEPOS. They are dependent on relationships with their preferred providers.

Beneficiaries may face considerable challenges to choice, quality, and access in obtaining DMEPOS under competitive bidding.

²⁴ In Round 1, 329 suppliers won bid contracts across nine CBAs (excluding San Juan, Puerto Rico) (See Department of Health and Human Services, 74 Fed. Reg. 2873-2881 (to be codified at 42 CFR Part 414)). There were 4,127 suppliers in those nine CBAs prior to the CB program (calculated from data released by CMS). $329 / 4,127 = 7.9$ percent. In other words 92.1 percent of suppliers in those nine CBAs were eliminated from the Medicare program. See: Centers for Medicare and Medicaid Services (2007, April 2). *New program reduces costs and improves access to high quality medical equipment and supplies for Medicare beneficiaries.* [Press release]. Retrieved from: https://list.nih.gov/cgi-bin/wa.exe?A2=ind0704&L=HHS_CMS_PRESS&F=&S=&P=2189

Potential Impact on Beneficiaries

Continuity of care will be disrupted for those beneficiaries whose current providers do not win bids, compromising supplier knowledge of the patient's condition, needs, and preferences. It is not clear how this continuity will be restored, given the restricted finances of suppliers under the competitive bidding program.

DMEPOS suppliers play an integral role in the three major components of beneficiary continuity of care: relational (ongoing provider-patient relationship), management (coordination of care), and informational (information transfer).²⁵ A higher value is placed on continuity of care for patients with increased age, medical complexity or medication use, and poor health status, which are all common attributes of the DMEPOS beneficiary population.²⁶ In particular, relationship continuity – or lack of transitions – is especially important for older patients, because of the greater likelihood of multiple chronic conditions that benefit from informed management and shared decision making.²⁷ Discontinuity of care forced by changes in coverage, such as the competitive bidding program will cause, can result in decreased provider knowledge of, and familiarity with, the patient and their condition, causing worsened coordination of care.²⁸

Among the bid winners, patients may have significantly less discretion in choosing suppliers based on quality and customer service because many suppliers will be eliminated based on price. Beneficiaries may not have a choice regarding whether the winning supplier delivers and how often the winning supplier serves a patient's area. Lack of choice between quality suppliers could lead to adverse consequences for beneficiaries in terms of their health status.

For many suppliers, Medicare is the predominant payer for their equipment and related services. It will be very difficult for many losing suppliers to remain in business without Medicare revenue during the three year period before prices are re-bid. For instance, large bid winners are already purchasing small bid winner inventory. As suppliers leave the DMEPOS market, competition and choice of supplier will be further limited during future rounds of competitive bidding.

CHOICE OF EQUIPMENT

In addition to new limits on choice of supplier, beneficiaries may experience new limits placed on the array of products that was available to them before the competitive bidding program. This phenomenon was observed during the demonstration project. Site visits

²⁵ Reid, R., Haggerty, J. McKendry, R. (2002). Defusing the confusion: Concepts and measures of continuity of health care. *Centre for Health Services and Policy Research*. Retrieved from: http://www.chsrf.org/final_research/commissioned_research/programs/pdf/cr_contcare_e.pdf

²⁶ Nutting, P.A., Goodwin, M.A., Flocke, S.A., Zyzanski, S.J., Stange, K.C. (2003). Continuity of primary care: To whom does it matter and when? *Annals of Family Medicine*, 1, 149-155.

²⁷ Sharma, G., Fletcher, K.E., Zhang, D., Kuo, Y., Freeman, J.L., Goodwin, J.S. (2009). Continuity of outpatient and inpatient care for hospitalized older adults. *Journal of the American Medical Association*, 301(16), 1671-1680.

²⁸ Flocke, S.A., Stange, K.C. Zyzanski, S.J. (1997). The impact of insurance type and forced discontinuity of care on the delivery of primary care. *The Journal of Family Practice*, 45, 129-35.

Potential Impact on Beneficiaries

during the demonstration suggested that some wheelchair suppliers attempted to cut costs by providing fewer accessories. Referral agents responded that they needed to be more vigilant in specifying orders and assuring their specifications were met.²⁹

Beneficiary choice will be limited if the product or piece of equipment they want/need is not specifically prescribed by modality or brand name by their physician or referral agent. Interview respondents noted that the referring agent or physician may not be familiar enough with DMEPOS to request the proper modality or brand name, and are unlikely to conduct an assessment of the patient at home.

Access

Beneficiary access to appropriate, high quality equipment that is provided in a timely manner may be seriously compromised in the new competitive bidding marketplace.

ACCESS TO SERVICES

Beneficiaries are not protected against, and may experience, difficulties accessing equipment and necessary services. These difficulties could arise if the bid winners in their competitive bidding areas are not in close proximity to them and either limit or discontinue home deliveries. In some cases, bid winners may only provide equipment by mail order, which could cause delays in delivery time and eliminate any assistive services for beneficiaries.

There is no requirement in the DMEPOS competitive bidding program regarding response time (i.e. delivery time). One former CMS contractor commented that winners of the competitive bidding program could increase efficiency by expanding their patient base and lowering their per unit delivery cost. However, the respondent noted that the capacity to respond quickly is expensive and that suppliers would likely cut costs to meet the new competitive bid prices by reducing the frequency or timeliness of delivery.

Delivery may further be impacted by restrictions on the competitive bidding product categories; whereas a supplier could increase efficiency by delivering multiple types of equipment, now they will only be able to deliver the product for which they won a contract. Response time is particularly important for patients being discharged from a hospital or skilled nursing facility who need prompt delivery in order to return home. Patients with long-term, chronic conditions, such as COPD, also need access to timely delivery in the event that their oxygen concentrator or other life-preserving equipment fails.

Reduced access to services could result in cost-shifting from the DMEPOS program, covered by Medicare Part B, to acute and post-acute facility-based care covered by

²⁹ Thompson, T. (2004). 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*. Washington, D.C.

Potential Impact on Beneficiaries

Medicare Part A. In the near term, beneficiaries may have to visit the emergency room if they experience problems with their equipment or supplies and cannot receive timely service. In the long term, they may have to move into a nursing home or other institutional setting to receive proper care.

ACCESS TO EQUIPMENT

The availability of clinically appropriate, complex products, such as portable liquid oxygen, customized power wheelchair accessories, and complex seating cushions, may decrease under the competitive bidding program. As prices fall, suppliers may substitute less expensive, standard, and non-customizable products for the high quality products they previously supplied. DMEPOS suppliers are not required to provide high quality or more expensive products within the same product category or code if it is not specifically prescribed by brand or modality. Access to customizable equipment is important for certain beneficiaries because it can ensure proper fit, support mobility, and prevent the development of complications (e.g. pressure ulcers). Without access to clinically appropriate equipment or support services, beneficiaries could lose their ability to live independently at home.

Beneficiaries who are currently able to obtain multiple types of DMEPOS products from the same supplier may be forced to use several suppliers. The potential ending of a beneficiary's relationship with their preferred supplier with the additional requirement to use multiple new suppliers for different types of DMEPOS products, will disrupt continuity of patient care and create significant confusion for beneficiaries. Beneficiaries without a discharge planner, many of whom will not receive the education and resources they need to navigate the new system, will be placed at risk for more medical emergencies.

Discharge planners in turn may be forced to coordinate several suppliers for each patient discharge, which will make it more difficult and complicated for beneficiaries to receive DMEPOS products and any related services that each separate piece may require (e.g. adjustment). DHHS' *Final Report to Congress* states that the competitive bidding program will likely complicate the activities of, and create heavier workloads for, discharge planners and physician offices, require more comparison shopping for beneficiaries, increase the amount of paperwork when multiple suppliers are used, and lead to discomfort and occasional interruption of service for beneficiaries.³⁰

Quality

The legislation establishing the competitive bidding program does not articulate any specific patient safeguards relating to marketing, enrollment and disenrollment, benefit design, or quality standards – unlike the Medicare Part D program. Competitive bidding is so focused

³⁰ Thompson, T. (2004). 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*. Washington, D.C.

Potential Impact on Beneficiaries

on price discounting that it provided the Secretary of DHHS the authority to pursue implementation of the program in the absence of quality standards.³¹ Supplier competition based on price, in the absence of beneficiary safeguards, may cause a significant decrease in the quality of both DMEPOS products and customer service.

QUALITY OF SERVICES

In order to meet new competitive bidding prices, suppliers will likely cut costs by reducing services for which they are not reimbursed but can afford to provide at the current price levels. Assistive services provided by DMEPOS suppliers are critical to maintaining the health and well-being of these beneficiaries. These services include beneficiary education and training; evaluation and assessment of patient need; timely delivery, repair, and replacement of equipment; and frequency and availability of service.

Additionally, it is unclear whether provisions in MIPPA that attempt to prevent unlicensed and inexperienced providers from winning bids in the Round 1 Re-bid, as occurred during Round 1, will be effective. Beneficiaries may not be protected from unlicensed or inexperienced providers winning bids in their competitive bidding areas.

QUALITY OF EQUIPMENT

As prices fall under the competitive bidding program, the quality of DMEPOS products supplied to beneficiaries will likely decrease. Many patient advocates expressed concern that quality of life may decrease accordingly for beneficiaries currently using more portable and expensive products that increase mobility and independence, such as complex power wheelchairs and portable liquid oxygen, if they experience difficulty obtaining these items.

In addition to losing higher quality products, beneficiaries may not be able to obtain more customized/specialized equipment or accessories (e.g. leg braces for a personalized wheelchair or “joysticks”). Medical complications may develop if beneficiaries are not fitted properly for or given necessary adjustments to the equipment they do receive.

Future development of high quality products may be stifled due to price constraints imposed by competitive bidding. The competitive bidding program may place financial pressures on DMEPOS manufacturers to either reduce research and development for innovative new technologies or stop production of certain product lines altogether, if they perceive there is no more market for more expensive or higher quality DMEPOS. One beneficiary and patient advocate who works closely with several DMEPOS manufacturers said during an interview that international manufacturers are looking to countries other than the United States to serve as future markets for new DMEPOS products because competitive bidding has limited the market for new, high quality equipment.

³¹ Rosenbaum, S., Dor, A., Finnegan, B., Jones, E. (2008). Medicare competitive acquisition: Implications for persons with diabetes. *The George Washington University School of Public Health and Health Services, Department of Health Policy.*

Unintended Consequences

A series of unintended consequences could result if Medicare beneficiaries face significant challenges to choice, access, and quality in obtaining DMEPOS products and services due to the competitive bidding program.

Infrequent or discontinued delivery by out-of-area suppliers, or growth in mail order-only suppliers, could cause delays in discharging patients from the hospital or skilled nursing facility. A reduction in other support services could result in increased beneficiary visits to the emergency department due to deteriorating medical condition.

Beneficiaries could also develop medical complications as a direct result of inadequate access to clinically appropriate equipment (e.g. pressure ulcers from improper seating cushions, hospitalization from fewer or irregular blood sugar testing, degradation of general health from lack of exercise due to mobility restrictions) that usually require more expensive medical care.

Improper equipment and reduced assistance from suppliers could increase the use of facility-based care if beneficiaries cannot maintain their independence at home. While the competitive bidding program may appear to produce savings for Medicare Part B, the program may, in actuality, be shifting costs from the DMEPOS benefit to acute care hospital and post-acute care facilities covered under Medicare Part A through increases in emergency department, hospital, and nursing home care.

Conclusion

In 2003, in addition to creating a competitive bidding program for DMEPOS products, MMA also ordered CMS to implement a competitive bidding program for diagnostic laboratory services. Amid concerns that CMS was not able to design a competitive bidding program that took into account the complexity of providing diagnostic laboratory testing services, the Laboratory Competitive Bidding Demonstration project was repealed in July 2008.³²

There is a fundamental miscalculation at CMS about how the DMEPOS benefit is working; while Medicare reimburses DMEPOS suppliers for delivering products, the program does not cover services, such as assessments, education and training, or repairs and maintenance. Like clinical laboratory testing, DMEPOS suppliers operate in a complex marketplace and provide both a product *and a service*. As prices fall, unreimbursed services will no longer be provided.

Medicare beneficiaries may face a variety of problems relating to choice, access, and quality in obtaining DMEPOS after the competitive bidding program is implemented on January 1, 2011. Due to a series of design flaws in the competitive bidding process, suppliers were incentivized to submit bids at “suicide” prices, which are not likely to be sustainable over the long-term as supplier capacity has to grow in order to meet demand.

Vulnerable Medicare beneficiaries that use DMEPOS are often disabled or have long-term, chronic conditions. In the absence of a treatment to cures their conditions, clinically appropriate and properly fitted DMEPOS is often the best and most cost-effective medical intervention and preserves their ability to live independently. The results of DMEPOS provider competition based on price, rather than quality of supplies or customer service, may result in significant reductions to the quality of items and services beneficiaries need to remain at home, independently. Unintended consequences that could result include secondary medical complications, increased emergency department visits and hospital discharge delays, and ultimately, a transition out of the home to more costly facility-based care.

³² American Clinical Laboratory Association. Competitive bidding for lab services is not the answer. Retrieved from: <http://www.clinical-labs.org/issues/bidding/index.shtml>

Conclusion

This report is intended to educate policymakers about the risks posed by the DMEPOS competitive bidding program to Medicare beneficiaries, so that future payment adjustments to the DMEPOS program may be carefully considered in light of broader beneficiary concerns.