

Issue Brief on the Risks to Medicare Beneficiaries of DMEPOS Competitive Bidding

Compromising Choice, Access, and Quality for Medicare's Most Vulnerable

Dobson | DaVanzo

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Exhibit 1: Executive Summary

- **Purpose:** To examine the potential impact of the competitive bidding (CB) program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) on Medicare beneficiaries.
- **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 a former CMS official.
- **Summary:** The design of the CB program leads to “desperation bidding” and reduced supplier prices, potentially causing Medicare’s most vulnerable beneficiaries to experience a range of unintended consequences that affect choice, access, and quality in the DMEPOS benefit. This could result in 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 have a negative impact on price, quality, and service for Medicare beneficiaries.
 - The design of the CMS CB process is highly susceptible to “gaming,” allowing sophisticated bidders to use complex rules and the volatility of supply and demand to their advantage.
 - The three-year bid period, the composite price structure used to calculate prices, 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 price competition over the long term, not more.
- **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.
- **Access:** As the number of suppliers is reduced, beneficiaries could experience problems accessing quality equipment and services, especially over time and by geographic area.
 - 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:** 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.

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1. Introduction and Purpose

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 comorbidities and impaired mobility, and represent a particularly vulnerable segment of the Medicare population.

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.³ In addition, 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 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, we conducted a series of key stakeholder interviews with hospital discharge planners, patient advocates, beneficiaries, independent academic experts, DMEPOS suppliers, and a former CMS official.

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.*

³ While the two most important consequences of deregulation in the airline industry have been lower fares and higher 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; incumbents responded by similar price cuts followed by comparable cuts in service. See: 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>.

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Exhibit 1 above provides a high level summary of our study findings.

This report starts with a description of 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 competitive bidding round bid winners.

We conclude that the competitive bidding program could ultimately result in increased costs for CMS and worse health outcomes for Medicare beneficiaries by causing medical complications, increased emergency department, hospital, and physician visits, hospital discharge delays, and nursing home admissions by limiting choice, access, and quality in DMEPOS products and services.

2. Beneficiaries Who Use DMEPOS

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

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, issues with mobility, and need several different types of DMEPOS products. These beneficiaries are not assisted by discharge planners in obtaining DMEPOS products, and rely heavily on direct relationships

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

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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.

3. Background

Medicare has paid for DMEPOS supplies through a fee schedule determined through administered reference pricing since 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 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,⁵ and no analysis of the competitive bidding program's long-term effects on market competition was ever conducted.⁶ 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 metropolitan statistical areas (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.⁷

⁵ 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.

⁶ 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 According to CMS, there were an estimated 2.7 million eligible beneficiaries living in the nine competitive bidding areas (CBAs) included in the Round 1 Re-bid in 2005. (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.

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4. Market-based Flaws in the Competitive Bidding Process

There are several problems inherent in CMS's design of the competitive bidding process that create perverse incentives and resulted 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.

- Two academic researchers noted that the length of time between re-bid periods (three years) locks producers and suppliers into a fixed price arrangement, which does not accurately reflect either prices or demand in a volatile market.
 - In addition, a fixed price period of three years does not account for new financial pressures that will be placed on DMEPOS suppliers due to both changes in demand (as eligibility changes under health care reform) and price reductions by other commercial and public payers.
- “Predatory pricing” to force out local competition, as used by Blockbuster Inc., for example, will reduce long run competition by smaller suppliers that cannot maintain business operations without Medicare business before the next bid period opens.
- The competitive bidding program also incentivizes small businesses to submit “suicide bids” in order to survive in the marketplace, though companies may not be able to sustain their business over the long term at these low prices.
 - The Director of the Chronic Care Policy Group at CMS said during a media phone call that 30 percent of the time, supplier bids were low enough to make CMS uncomfortable with the bid price and caused CMS to disregard suppliers’ stated capacity to serve beneficiaries.⁸
 - In a poll of nearly 400 DMEPOS providers in August 2010, over 80 percent of respondents said the bid prices were too low to accept. Bid winners indicated they would meet new prices by cutting services and providing less expensive, low quality equipment.⁹
 - Anecdotal evidence from interviews with DMEPOS suppliers and patient advocates who work closely with suppliers indicated that many small businesses submitted alarmingly low bids out of fear they would be forced to close, and are now concerned about how to operate within the new prices.

⁸ 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>.

⁹ 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=hm201007vNHYS>.

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- The Department of Health and Human Services' (DHHS) *Final Report to Congress* on the demonstration evaluation reports that, “inexperienced bidders may bid too aggressively low at the outset.”¹⁰
- The method used to calculate the bid price for each item creates opportunities for “gaming” the system and produces other negative consequences.
 - Bidders are not held to the bid price they submit, and 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.
 - Using the median bid price, half of the initial bid winners will be offered a price below their actual bid.
 - 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.
 - 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.
 - 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 2006,¹¹ allows sophisticated bidders to bid higher on large volume items and lower on small volume items while maintaining a low overall composite bid.¹²
- CMS did not independently assess the capacity of suppliers to provide service, and did not release methodology used to assess financial viability standards.
 - 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 2011.¹³⁻¹⁴

¹⁰ 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.

¹¹ 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.

¹² Katzman, B., McGeary, K.A. (2008). Will competitive bidding decrease Medicare prices? *Southern Economics Journal*, 74(3), 839-856.

¹³ 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.

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/>.

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- The accreditation process is necessary, but doesn't 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.¹⁵
- CMS used a flawed pricing system that groups products and devices that are of substantially different quality together into categories; these products and services will not then 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 wholesale product substitution even when clinical customization may be essential."¹⁶
- The consequences of competitive bidding from a game theory perspective are unpredictable – the entire CMS competitive bidding process is a "home grown" set of rules that distorts true marketplace dynamics and may or may not be beneficial to Medicare beneficiaries over either the short or long term.

5. Potential Impact on Beneficiaries

CHOICE

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

- Up to 90 percent of current DMEPOS suppliers could be eliminated from the Medicare program across all competitive bidding areas included in the program.¹⁷
- Beneficiaries cannot choose to remain with their preferred supplier if their current supplier is eliminated in the bidding process or does not grandfather current patients.
- Every patient advocate interviewed agreed that long-term relationships with providers and continuity of care are extremely important to beneficiaries with chronic conditions and severe disabilities. 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.
 - DMEPOS suppliers play an integral role in the three major components of beneficiary continuity of care: relational (ongoing provider-patient

¹⁵ 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>.

¹⁶ 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*.

¹⁷ 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 spreadsheets 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.

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relationship), management (coordination of care), and informational (information transfer).¹⁸

- Increased age, medical complexity or medication use, and poor health status – all common attributes of the DMEPOS beneficiary population – are associated with a higher value placed on continuity of care.¹⁹
 - 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.²⁰
- Discontinuity forced by changes in coverage can result in decreased provider knowledge of, and familiarity with, the patient and their condition, causing worsened coordination of care.²¹
- 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.
- 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 a physician or referral agent (who may not be familiar with DMEPOS and is not likely to conduct an assessment of the patient at home).
 - Site visits 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.²²
- 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, which will limit competition and choice during future rounds of competitive bidding.

¹⁸ 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.

¹⁹ 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.

²⁰ 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.

²¹ 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.

²² 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.

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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.

- 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 on price discounting that it provided the Secretary of DHHS the authority to pursue implementation of the program in the absence of quality standards.²³
- Beneficiaries are not protected against, and may experience, difficulties accessing equipment and necessary services if the bid winners in their competitive bidding areas: 1) are not in close proximity to them, 2) do not offer or limit home deliveries, or 3) only provide equipment by mail order.
- There is no requirement in the rules establishing the DMEPOS competitive bidding program regarding response time (i.e. delivery time). As the capacity to respond quickly is expensive, and suppliers may only win bids in one or a select few product categories, suppliers may limit the frequency of delivery service and notably increase response time.
 - Response time is particularly important for patients being discharged from a hospital or skilled nursing facility.
- Availability of clinically appropriate, complex products, such as portable liquid oxygen, customized power wheelchair accessories, and complex seating cushions, may decrease as prices fall and suppliers substitute less expensive, standard, and non-customizable products.
 - Customization is important to ensure proper fit, support mobility, and prevent the development of complications (e.g. pressure ulcers).
 - Suppliers are not required to provide high quality or more expensive products within the same product category or code.
- Without access to clinically appropriate equipment or necessary support services, beneficiaries could lose their ability to live independently at home.
 - In the near term, beneficiaries may have to visit the emergency room if they experience problems with their supplies or equipment 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.

²³ 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.*

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- Beneficiaries who are currently able to obtain multiple types of DMEPOS products from the same supplier may be forced to use several suppliers. Discharge planners 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).
 - Changing a beneficiary's relationship with their supplier, with the additional requirement that they use multiple new suppliers for different types of DMEPOS products, will add confusion for beneficiaries and disrupt continuity of patient care.
 - DHHS' *Final Report to Congress* admits 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.²⁴
- The competitive bidding program may place financial pressure 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.

QUALITY

Supplier competition based on price may cause a significant decrease in the quality of both DMEPOS products and customer service.

- In order to meet new competitive bidding prices, suppliers will likely cut costs by reducing services for which they are not currently reimbursed but can afford to provide, such as beneficiary education and training; evaluation and assessment of patient need; timely delivery, repair, and replacement of equipment; and frequency and availability of service.
- 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 in protecting beneficiaries from these types of providers winning bids in their competitive bidding areas.
- Many patient advocates expressed concern that quality of life may decrease for beneficiaries currently using more portable and expensive products that increase

²⁴ 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.

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mobility and independence, such as complex power wheelchairs and portable liquid oxygen, if they are no longer able to receive these items.

- In addition to losing higher quality products, beneficiaries may not be able to obtain more customized/specialized equipment or accessories (e.g. personalized wheelchair leg braces or “joysticks”) or be fitted properly for and have adjustments made to the equipment they do get, which can also result in medical complications.
- As prices fall under the competitive bidding program, the quality of DMEPOS supplied to beneficiaries will likely decrease and the development of higher quality products may be stifled due to price constraints.

6. Likely Result: Vulnerable Beneficiaries with Complex Medical Conditions May Face Unintended Consequences

A series of unintended consequences could result if beneficiaries face the challenges to choice, access, and quality products and services in the Medicare DMEPOS benefit.

- Beneficiaries could 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, etc.) that usually require more expensive medical care.
- Infrequent delivery schedules by out-of-area suppliers could cause delays in discharging patients from the hospital.
- Reduced support services could result in increased beneficiary visits to the emergency department due to deteriorating medical condition.
- Improper equipment and reduced assistance from suppliers could increase the use of facility-based care if beneficiaries cannot maintain independence at home.

7. 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. Laboratory services represent approximately 2 percent of annual Medicare expenditures. 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 2008.²⁵

²⁵ American Clinical Laboratory Association. Competitive bidding for lab services is not the answer. Retrieved from: <http://www.clinical-labs.org/issues/bidding/index.shtml>.

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There is a fundamental misunderstanding 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 assessment, education and training, or repair 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 not 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 to meet demand.

Vulnerable Medicare beneficiaries that use DMEPOS are often disabled or have long term, chronic conditions. In the absence of treatment that cures their conditions, clinically appropriate and properly fitted DMEPOS is often the best and most cost-effective medical intervention that 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, living 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.

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 more carefully considered.