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MEDICARE

The First Year of the Durable Medical Equipment Competitive Bidding Program Round 1 Rebid

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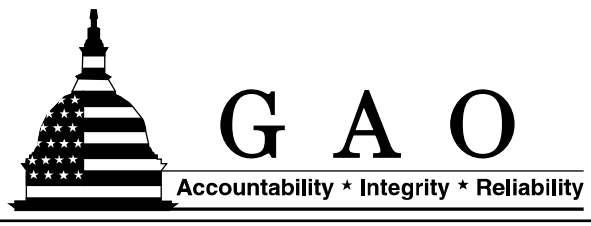

Chairman Herger, Ranking Member Stark, and Members of the Subcommittee:

I am pleased to be here today to discuss the Medicare[1] competitive bidding program for selected durable medical equipment (DME) and certain other items. My testimony today is focused on our review of the Centers for Medicare & Medicaid Services (CMS)[2] implementation of the competitive bidding program (CBP) round 1 rebid that began on January 1, 2011.

Most Medicare beneficiaries participate in Medicare Part B,[3] which helps pay for DME items, such as oxygen, wheelchairs, hospital beds, walkers, as well as prosthetics, orthotics, and related supplies. Medicare beneficiaries typically obtain DME items from suppliers, which submit claims for payment to Medicare on behalf of beneficiaries. Both we and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have reported that Medicare and its beneficiaries have sometimes paid higher-than-market rates for various medical equipment

[1]Medicare is a federal health insurance program for people age 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease.

[2]CMS is an agency within the Department of Health and Human Services that has responsibility for administering the Medicare program.

[3]Medicare Part B helps pay for certain physician, outpatient hospital, laboratory and other services, and medical equipment and supplies—DME. Beneficiaries are required to pay a monthly premium for Part B coverage, an annual deductible, and coinsurance. In general, Medicare beneficiaries pay 20 percent—the coinsurance—of the Medicare fee schedule payment rate for the DME item after reaching their annual Medicare Part B deductible. In 2010, CMS reported that Medicare Part B and beneficiaries paid approximately $14.3 billion for DME and related items.

and supply items.[4] These overpayments increase costs to both Medicare and its beneficiaries.

To achieve Medicare savings for DME, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required that CMS implement the CBP for certain DME. CMS began implementing the first round of the CBP in 2007 and 2008—but 2 weeks after the round 1 began, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) terminated the first round of supplier contracts and required CMS to repeat the CBP round 1—the round 1 rebid. In 2009, CMS began implementing the round 1 rebid, which resulted in the award of contracts to suppliers with payments that began on January 1, 2011. Nine competitive bidding areas[5] and nine product categories[6] for selected

[4]GAO, *Medicare: CMS Has Addressed Some Implementation Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program for the Round 1 Rebid*, GAO-10-1057T (Washington, D.C.: Sept. 15, 2010); GAO, *Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program,* GAO-10-27 (Washington, D.C.: Nov. 6, 2009); GAO, *Medicare: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical* GAO-08-767T (Washington, D.C.: May 6, 2008); GAO, *Medicare: Past Experience Can Guide Future Competitive Bidding for Medical Equipment and Supplies*, GAO-04-765 (Washington, D.C.: Sept. 7, 2004); Department of Health and Human Services Office of Inspector General, *A Comparison of Prices for Power Wheelchairs in the Medicare Program*, OEI-03-03-00460 (Washington, D.C.: April 2004); and Janet Rehnquist, Inspector General, Department of Health and Human Services, *Medicare Reimbursement for Medical Equipment and Supplies*, testimony before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, 107th Cong., 2nd sess., June 12, 2002.

[5]The nine CBP round 1 rebid competitive bidding areas are: Charlotte (Charlotte-Gastonia-Concord, North Carolina and South Carolina); Cincinnati (Cincinnati-Middletown, Ohio, Kentucky, and Indiana); Cleveland (Cleveland-Elyria-Mentor, Ohio); Dallas (Dallas-Fort Worth-Arlington, Texas); Kansas City (Kansas City, Missouri and Kansas); Miami (Miami-Fort Lauderdale-Pompano Beach, Florida); Orlando (Orlando-Kissimmee, Florida); Pittsburgh (Pittsburgh, Pennsylvania); and Riverside (Riverside-San Bernardino-Ontario, California).

[6]The CBP round 1 rebid's nine product categories are: complex power wheelchairs (complex rehabilitative power wheelchairs and related accessories—limited to group 2—power wheelchairs with power options); CPAP/RAD (continuous positive airway pressure devices, respiratory assist devices, and related supplies and accessories); enteral (enteral nutrients, equipment, and supplies); hospital beds (hospital beds and related accessories); mail-order diabetic supplies; oxygen (oxygen supplies and equipment); standard power wheelchairs (standard power wheelchairs, scooters, and related accessories); walkers (walkers and related accessories); and support surfaces (support surfaces limited to group 2 mattresses and overlays—pressure reducing support surfaces for persons with or at high risk for pressure ulcers—in the Miami competitive bidding area only).

DME items were included in the CBP round 1 rebid. CMS has estimated that the rebid will lead to significant savings for Medicare.

MIPPA also required us to examine particular issues regarding early results from the ongoing CBP round 1 rebid.[7] We reviewed (1) the outcomes of the CBP round 1 rebid process including bid disqualifications and contracts awarded; (2) the effect of the CBP round 1 rebid on DME suppliers; (3) how the CBP round 1 rebid has affected Medicare beneficiary access to and satisfaction with selected DME; and (4) the extent to which the CBP round 1 rebid has affected the utilization of selected DME items.

My remarks today are based on our report, released today, *Medicare: Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid*.[8] In that report, to examine CBP outcomes and effects, we analyzed data from CMS and its feedback provided to bidding suppliers, analyzed 2011 CBP data about different types of suppliers, and interviewed CMS and CBP contractor officials, DME industry groups, and suppliers. To examine the CBP's effects on beneficiary access, we analyzed Medicare claims data for the first 6 months of 2011, because claims data for those months were the most complete, and compared that data to the same months in 2010. Our findings on the first year of the round 1 rebid are based on the limited evidence available at the time we did our work; more data will become available as the CBP continues. CMS officials commented on a draft of our report. Our work was performed in accordance with generally accepted government auditing standards from May 2011 through May 2012 for both the report and for this statement.

Our work on the outcomes of the CBP round 1 rebid found that the number of bidding suppliers and the number of contracts awarded in the CBP round 1 rebid were very similar to the CBP round 1 and about a third of the 1,011 suppliers that bid in the rebid were awarded at least one CBP contract. CMS made improvements to the bidding process for the CBP round 1 rebid—such as providing additional information about disqualification reasons—and significantly fewer bids were disqualified than in round 1. However, many suppliers still had difficulty meeting bid

[7]Pub. L. No. 110-275, § 154(c), 122 Stat. at 2565-6.

[8]GAO-12-683 (Washington, D.C.: May 9, 2012).

requirements. Of the bids that were disqualified during the initial bid review, 73 percent were disqualified because suppliers failed to provide the required financial documentation or did not meet CMS's minimum financial standard threshold for suppliers.[9] The number of bids disqualified for missing financial documentation in the CBP round 1 rebid would have been higher if many suppliers had not benefited from a MIPPA provision that required that CMS provide suppliers the opportunity to be notified of and to submit missing required financial documentation—a process not available during CBP round 1. As a result, 93 of the 321 suppliers—about 29 percent—that were notified by CMS that they had missing financial documentation, and subsequently provided correct documentation, were ultimately awarded one or more CBP contracts. In the CBP round 1 rebid, as in CBP round 1, CMS determined that some suppliers' bids had been disqualified incorrectly. CMS told us it received bid inquiries from 99 suppliers that had bids disqualified in the CBP round 1 rebid and subsequently extended contracts to 7 of those suppliers that were found to have incorrectly disqualified bids.

During CBP's first year, few contract suppliers—those awarded CBP contracts—had their contracts terminated by CMS, voluntarily canceled their contracts, or were involved in ownership changes. Under the CBP, many non-contract suppliers—those that were not awarded CBP contracts—exercised the option to grandfather certain CBP-covered rental DME items for beneficiaries they were furnishing prior to the implementation of the CBP. Many grandfathered suppliers, for example, continued to furnish the CBP-covered oxygen product category to their beneficiaries. The number of these suppliers generally decreased steadily throughout the first year as CBP-covered beneficiaries' rental periods expired or as beneficiaries chose contract suppliers. Some contract suppliers entered into subcontracting agreements with non-contract suppliers to furnish certain services to CBP-covered beneficiaries. As the CBP allows, some contract suppliers were awarded contracts for product categories that they did not have prior experience in, or for competitive bidding areas where they did not have a prior business location.

CMS's on-going monitoring activities generally indicate that beneficiary DME access and satisfaction have not been affected by the CBP. Although some of these efforts have limitations, in the aggregate, they

[9]These bids may also have been disqualified for other reasons.

provide useful information to CMS regarding beneficiary access and satisfaction. CBP-related calls to 1-800-MEDICARE declined during the first year of CBP implementation. Two percent of calls were from beneficiaries with an urgent need for CBP-covered DME. Of 127,466 inquiries in 2011, CMS classified 151 as complaints.[10] Seventy-seven percent of CBP complaints—or 116 complaints—occurred in the first half of 2011. CMS's pre-and post-implementation beneficiary satisfaction survey did not reveal systemic beneficiary access or satisfaction problems with the CBP, although the survey's questions were limited. For all six questions regarding the CBP, nearly 90 percent of beneficiaries reported their service as being "good" or "very good". Beneficiary satisfaction survey results within competitive bidding areas show a drop of one to three percentage points on each of the six questions from pre-implementation in 2010 to post-implementation in 2011. CMS tracks health outcomes including, for example, hospitalizations, physician visits, and deaths, for beneficiaries potentially affected by the CBP. While the data do not show directly whether outcomes were caused by problems accessing CBP-covered DME, CMS reports no changes in health outcomes for beneficiaries living in competitive bidding areas in 2011.

Medicare claims data from the first 6 months of the CBP round 1 rebid show that fewer distinct CBP-covered beneficiaries[11] in competitive bidding areas received DME items in 2011 than in 2010 for the six CBP product categories that we analyzed.[12] For example, the number of distinct beneficiaries receiving hospital bed product category items in the CBP areas was about 13 percent lower in May 2011 than the distinct beneficiaries receiving these items in May 2010. However, we do not

[10]CMS defines a CBP complaint as a CBP inquiry that cannot be resolved by any customer service representative with 1-800-MEDICARE and is sent to another entity—such as a CMS regional office—for resolution.

[11]Each distinct Medicare beneficiary is only counted once in each of the 6 months analyzed in 2010 and 2011 for each product category in a competitive bidding area, regardless of how many items that beneficiary received.

[12]We did not include these round 1 rebid product categories: (1) the mail-order diabetic testing supplies category due to some beneficiaries switching to non-mail-order sources, a concern being studied by the HHS OIG; (2) the complex power wheelchair category due to potential data reliability concerns reported by a CMS contractor; and (3) the support surfaces category because it is limited to only the Miami competitive bidding area in the round 1 rebid.

assume that utilization in 2010 was the appropriate level of Medicare utilization and the decline in the number of beneficiaries served between 2010 and 2011 does not necessarily indicate that beneficiaries did not have access to needed DME.

Although the first year of the CBP round 1 rebid has been completed, it is too soon to determine its full effects on Medicare beneficiaries and DME suppliers. Although we found that the round 1 rebid was, in general, successfully implemented, our findings are based on the limited data available at the time we did our study and for only the first year of the rebid's contract period. While the prevalence of grandfathered suppliers for some CBP rental items may have ameliorated beneficiary access concerns during the first year, the number of grandfathered suppliers will continue to decrease as rental agreements expire. Likewise, it is not yet known whether any change in the number of subcontracting suppliers will affect beneficiary access. Therefore, more experience with DME competitive bidding is needed, particularly to see if evidence of beneficiary access problems emerges. For that reason, it is important to continue to monitor changes in the number of suppliers serving CBP-covered beneficiaries and trends in utilization of the CBP-covered DME.

Chairman Herger, Ranking Member Stark, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

If you or your staff have any questions about this testimony, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are listed in appendix I.

Appendix I: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Martin T. Gahart, Assistant Director; Michelle Paluga; Katherine Perry; and Opal Winebrenner were key contributors to this statement.