

**GAO**

Testimony

Before the Subcommittee on Health,  
Committee on Ways and Means, House of  
Representatives

---

For Release on Delivery  
Expected at 1:00 p.m. EDT  
Tuesday, May 6, 2008

**MEDICARE**

**Competitive Bidding for  
Medical Equipment and  
Supplies Could Reduce  
Program Payments, but  
Adequate Oversight Is  
Critical**

Statement of Kathleen M. King  
Director, Health Care





Highlights of [GAO-08-767T](#), a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

## Why GAO Did This Study

For more than a decade, GAO has reported that Medicare has paid higher than market rates for medical equipment and supplies provided to beneficiaries under Medicare Part B. Since 1989, Medicare has used fee schedules primarily based on historical charges to set payment amounts. But this approach lacks flexibility to keep pace with market changes and increases costs to the federal government and Medicare's 44 million elderly and disabled beneficiaries. The Balanced Budget Act of 1997 required the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—to test competitive bidding as a new way to set payments. CMS did this through a demonstration in two locations in which suppliers could compete on the basis of price and other factors for the right to provide their products. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to conduct competitive bidding on a large scale and suppliers to obtain accreditation.

GAO was asked to describe the effects that competitive bidding could have on Medicare program payments and suppliers and the need for adequate oversight to ensure quality and access for beneficiaries in a competitive bidding environment. This testimony is based primarily on GAO work conducted from May 1994 to January 2007, which GAO updated by interviewing CMS officials and reviewing agency documents.

To view the full product, including the scope and methodology, click on [GAO-08-767T](#). For more information, contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

## MEDICARE

### Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical

#### What GAO Found

Competitive bidding could reduce Medicare program payments by providing an incentive for suppliers to accept lower payments for items and services to retain their ability to serve beneficiaries and potentially increase their market share. Fundamentally different from fee schedules based on historical charges to Medicare, competitive bidding allows the market to help CMS determine payment amounts. In the demonstration, the new fee schedule amounts were based on the winning suppliers' bids for items included and 50 percent to 55 percent of the bids from suppliers were selected. Evidence from CMS's competitive bidding demonstration suggests that competition saved Medicare \$7.5 million and saved beneficiaries \$1.9 million—without significantly affecting beneficiary access. For the competitive bidding program, CMS required suppliers to obtain accreditation based on quality standards and provide financial documents to participate. This added scrutiny gives CMS the chance to screen out suppliers that may not be stable, legitimate businesses, which could contribute to lower rates of improper payment. CMS also evaluated the bids based on demand, capacity, and price and chose suppliers whose bids were at or under a certain amount. CMS estimates that the first round of its competitive bidding program will result in payment amounts that average 26 percent less than the current fee schedule amounts. Competitive bidding also changes Medicare's relationship with suppliers and departs from Medicare's practice of doing business with any qualified provider, because it is designed to limit the number of suppliers to those whose bids are at or under a certain amount.

Because of concerns that competitive bidding may prompt suppliers to cut their costs by providing lower-quality items and curtailing services, ensuring quality and access through adequate oversight is critical for the success of the competitive bidding program. In September 2004, GAO indicated that quality assurance steps could include monitoring beneficiary satisfaction, setting standards for suppliers, giving beneficiaries a choice of suppliers, and selecting winning bidders based on quality and the dollar amount of the bids. As competitive bidding expands, problems that beneficiaries might experience could be magnified. Therefore, continued monitoring of beneficiary satisfaction will be critical to identify problems with suppliers or with items provided to beneficiaries. As required in the MMA, GAO will review and report on the competitive bidding program's impact on suppliers and manufacturers and its effect on quality and access for beneficiaries.

---

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here as you discuss the Medicare competitive bidding program for durable medical equipment (DME), prosthetics, orthotics, and supplies—products referred to in this statement as medical equipment and supplies.<sup>1</sup> For more than a decade, we and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have periodically reported that Medicare, administered by the Centers for Medicare & Medicaid Services (CMS), has paid higher than market rates for various medical equipment and supply items.<sup>2</sup> These overpayments increase costs to the program and to Medicare’s 44 million elderly and disabled beneficiaries. CMS reported in 2007 that total Medicare expenditures for medical equipment and supplies were about \$10 billion.<sup>3</sup>

Since 1989, Medicare has paid for medical equipment and supplies through fee schedules that list a maximum and minimum payment amount. The schedules are based on average supplier charges on Medicare claims in 1986 and 1987 and have been updated in some years to reflect inflation.<sup>4</sup> However, this payment approach lacks flexibility to keep pace with market changes, and as a result, Medicare often pays higher prices than other public payers for medical equipment and supplies. The Balanced Budget Act of 1997 (BBA)<sup>5</sup> required CMS to test competitive bidding as a new way for Medicare to set fees for Part B items and services specified by CMS, which the agency did through a demonstration focused on medical

---

<sup>1</sup>Medicare guidance defines DME as equipment that serves a medical purpose, can withstand repeated use, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home. DME includes items such as wheelchairs, hospital beds, and walkers. Medicare defines prosthetic devices (other than dental) as devices that are needed to replace body parts or functions. Prosthetic devices include artificial limbs and eyes, enteral nutrients, ostomy bags, and cardiac pacemakers. Medicare defines orthotic devices to include leg, arm, back, and neck braces that provide rigid or semirigid support to weak or deformed body parts or restrict or eliminate motion in a diseased or injured part of the body. Medicare-reimbursed supplies are items that are used in conjunction with DME and are consumed during the use of the equipment, such as drugs used for inhalation therapy, or need to be replaced frequently (usually daily), such as surgical dressings.

<sup>2</sup>A list of related GAO products is included at the end of this statement.

<sup>3</sup>These expenditures reflect claims submitted April 1, 2006, through March 31, 2007.

<sup>4</sup>CMS has established a process to price new items that are added to the fee schedule.

<sup>5</sup>Pub. L. No. 105-33, § 4319(a), 111 Stat. 251, 392 (1997).

---

equipment and supplies.<sup>6</sup> Competitive bidding is a process in which suppliers of medical equipment and supplies compete for the right to provide their products on the basis of established criteria, such as quality and price. About a year after the demonstration concluded, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to conduct a competitive bidding program for DME, supplies, off-the-shelf orthotics, and enteral nutrients and related equipment and supplies on a large scale.<sup>7</sup>

In my testimony today, I will discuss (1) the effects that competitive bidding could have on Medicare program payments and suppliers and (2) the need for adequate oversight to ensure quality and access for beneficiaries in a competitive bidding environment. My testimony is based primarily on our previously issued work, conducted from May 1994 to January 2007, which we updated with information on the competitive bidding process by interviewing CMS officials and reviewing agency documents. We shared a statement of facts regarding this testimony with CMS and incorporated the agency's comments as appropriate. We conducted this performance audit from April 2008 through May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, competitive bidding could reduce Medicare program payments by providing an incentive for suppliers to accept lower payments for items and services to retain their ability to serve beneficiaries and potentially increase their market share. Fundamentally different from fee schedules based on historical charges to Medicare, competitive bidding allows the market to help CMS determine payment amounts. In the demonstration, the new fee schedule amounts were based

---

<sup>6</sup>Medicare Part B helps pay for certain physician, outpatient hospital, laboratory, and other services, and medical equipment and supplies. Beneficiaries are required to pay a monthly premium for their Part B coverage.

<sup>7</sup>The competitive bidding program changes the way that Medicare determines the payment amounts for medical equipment and supplies by replacing the current fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bids submitted by Medicare suppliers. Pub. L. No. 108-173, § 302(b), 117 Stat. 2066, 2224.

---

on the winning suppliers' bids for items included and 50 percent to 55 percent of the bids from suppliers were selected. Evidence from CMS's competitive bidding demonstration suggests that competition saved Medicare \$7.5 million and saved beneficiaries \$1.9 million—without significantly affecting beneficiary access. For the competitive bidding program, CMS required suppliers to obtain accreditation based on quality standards<sup>8</sup> and provide financial documents to participate. This added scrutiny gives CMS the chance to screen out suppliers that may not be stable, legitimate businesses, which could contribute to lower rates of improper payment. CMS also evaluated the bids based on demand, capacity, and price and chose suppliers whose bids were at or under a certain amount. CMS estimates that the first round of its competitive bidding program will result in payment amounts that average 26 percent less than the current fee schedule amounts. Competitive bidding also changes Medicare's relationship with suppliers and departs from Medicare's practice of doing business with any qualified provider, because it is designed to limit the number of suppliers to those whose bids are at or under a certain amount.

Because of concerns that competitive bidding may prompt suppliers to cut their costs by providing lower-quality items and curtailing services, ensuring quality and access through adequate oversight is critical for the success of the competitive bidding program. In September 2004, GAO indicated that quality assurance steps could include monitoring beneficiary satisfaction, setting standards for suppliers, giving beneficiaries a choice of suppliers, and selecting winning bidders based on quality and the dollar amount of the bids. As competitive bidding expands, problems that beneficiaries might experience could be magnified. Therefore, continued monitoring of beneficiary satisfaction will be critical to identify problems with suppliers or with items provided to beneficiaries. As required in the MMA, GAO will review and report on the competitive bidding program's impact on suppliers and manufacturers and its effect on quality and access for beneficiaries.

---

<sup>8</sup>The quality standards are to be applied by one or more independent accreditation organizations designated by the agency. Accreditation is a process of certifying that health care organizations comply with specific standards and requirements.

---

## Background

Medicare is the federal program that helps pay for a variety of health care services for about 44 million elderly and disabled beneficiaries. Most Medicare beneficiaries participate in Medicare Part B, which helps pay for certain physician, outpatient hospital, laboratory, and other services; medical equipment and supplies, such as oxygen, wheelchairs, hospital beds, walkers, orthotics, prosthetics, and surgical dressings; and certain outpatient drugs.<sup>9</sup> Medicare Part B pays for most medical equipment and supplies using a series of fee schedules. Generally, Medicare has a separate fee schedule for each state that includes most items, and there are upper and lower limits on the allowable amounts that can be paid in different states to reduce variation in what Medicare pays for similar items in different parts of the country. Medicare pays 80 percent of the lesser of the actual charge for the item or fee schedule amount for the item, and the beneficiary pays the balance. Beneficiaries typically obtain medical equipment and supplies from suppliers, who submit claims to Medicare on beneficiaries' behalf. Suppliers include medical equipment retail establishments and outpatient providers, such as physicians, home health agencies, and physical therapists. To handle claims processing for medical equipment and supplies, CMS contracts with durable medical equipment Medicare administrative contractors.

---

## The Competitive Bidding Demonstration

Using its authority under the BBA, CMS conducted a competitive bidding demonstration to set Medicare Part B payment rates for groups of selected medical equipment and supplies.<sup>10</sup> CMS contracted with Palmetto Government Benefits Administrators (Palmetto) to administer the competitive bidding demonstration,<sup>11</sup> which was implemented in two

---

<sup>9</sup>Outpatient drugs covered under Part B include self-administered drugs, such as certain immunosuppressive and oral anticancer drugs, or drugs administered in conjunction with DME, such as inhalation drugs used with a nebulizer. A nebulizer is a device driven by a compressed air machine that allows the patient to take medicine in the form of a mist or wet aerosol.

<sup>10</sup>These groups were enteral nutrients, equipment and supplies, hospital beds and accessories, nebulizer inhalation drugs, manual wheelchairs and accessories, noncustomized general orthotics, oxygen contents, equipment and supplies, surgical dressings, and urological supplies.

<sup>11</sup>In this role, Palmetto was responsible for helping to plan the demonstration; educating beneficiaries, suppliers, and other stakeholders about the demonstration; soliciting and evaluating bids; processing claims; and responding to inquiries and complaints about the demonstration. CMS maintained oversight responsibility for the demonstration, reviewed all documents and Palmetto decisions, and made final design and policy decisions.

---

locations—the Polk County, Florida, metropolitan statistical area and parts of the San Antonio, Texas, metropolitan statistical area.

Two cycles of bidding took place in Polk County, with competitively set fees effective from October 1, 1999, to September 30, 2001, and from October 1, 2001, to September 30, 2002. One cycle of bidding took place in San Antonio, and competitively set fees were effective from February 1, 2001, to December 31, 2002. Bidding and implementation processes were similar at both locations. The demonstration ended on December 31, 2002.

---

## The Competitive Bidding Program

In December 2003, the MMA required CMS to conduct competitive bidding for DME, supplies, off-the-shelf orthotics, and enteral nutrients and related equipment and supplies on a large scale.<sup>12</sup> The MMA required that competition under the program begin in 10 of the largest metropolitan statistical areas in 2007, in 80 of the largest metropolitan statistical areas in 2009, and in other areas after 2009. The law established a new accreditation requirement for all Medicare suppliers of medical equipment and supplies and required CMS to develop financial and quality standards to use in selecting suppliers for the competitive bidding program. The law required CMS to take appropriate steps to ensure that small suppliers have an opportunity to be considered for participation in the competitive bidding program. CMS was required to establish a methodology for selecting bids from suppliers so that enough suppliers were selected to meet demand for competitively bid items within a given area. The law specified that at least two suppliers would be selected in each competitive area. The law also precluded judicial or administrative review of CMS's decisions to establish payment amounts, award contracts, designate areas for competition, select items and services, phase in implementation, and determine the bidding structure and number of suppliers selected under the competitive bidding program. The MMA required that an advisory committee be established to assist in carrying out the program.

To help implement the competitive bidding program, CMS published its notice of proposed rulemaking on May 1, 2006, and its final rule on April 10, 2007. CMS's final rule provided more detail on the agency's implementation steps. For example, the law specified that the agency could not award a contract to an entity unless it met applicable financial standards specified by the Secretary of HHS. In its regulation, CMS

---

<sup>12</sup>Pub. L. No. 108-173, § 302(b), 117 Stat. 2066, 2224.

---

specified the financial documents that had to be submitted by suppliers to be considered as potential bidders. Similarly, while the law indicated that the agency needed to ensure that small suppliers had an opportunity to participate, the regulation sets out a process to include a certain number of small suppliers based on the percentage of those who bid and met all applicable requirements.

CMS established the initial round of bidding in 10 metropolitan statistical areas that included Charlotte, N.C.; Cincinnati, Ohio; Cleveland, Ohio; Dallas, Tex.; Kansas City, Mo.; Miami, Fla.; Orlando, Fla.; Pittsburgh, Pa.; Riverside, Calif.; and San Juan, P.R. On April 9, 2007, CMS opened the initial registration of suppliers for the first round of bidding and the bid period opened on May 15, 2007. As part of its program implementation for the first round, CMS conducted a supplier-education campaign, which included meetings, listserve announcements, a dedicated Web site, and a toll-free help desk. The bid period closed on September 25, 2007. CMS concluded bid evaluations and began the contracting process in March 2008, and the agency plans to announce the first round of winning suppliers in May 2008. Suppliers whose bids were disqualified because their bid did not meet program and bidding requirements will receive a letter informing them of the reason or reasons for their disqualification. After the program begins, suppliers whose bids were not chosen generally cannot receive Medicare payment for the competitively bid items in the metropolitan statistical areas included in the competitive bidding program. However, suppliers of certain rental items or oxygen that did not become suppliers in the competitive bidding program could continue to serve their existing Medicare customers. Suppliers that did not have bids chosen in the first round of the program may bid in the future rounds of competition. CMS said it plans to conduct a beneficiary-education campaign before the program goes into effect on July 1, 2008.

---

## Competitive Bidding Could Reduce Program Payments by Creating an Incentive for Suppliers to Accept Lower Payment Amounts

Competitive bidding could reduce Medicare program payments by providing an incentive for suppliers to accept lower payment amounts for items and services to retain their ability to serve beneficiaries and potentially increase their market share. Using competition to obtain market prices in order to set payments for medical equipment and supplies is a new approach for Medicare that is fundamentally different than relying on fee schedules based on suppliers' historical charges to Medicare. Competitive bidding allows the market to provide information to CMS on what amounts suppliers will accept as payment to serve beneficiaries.



---

In its demonstration, CMS used a competitive bidding process to determine which suppliers would be included and the competitively set fees that they would be paid. From among the bidders, the agency and Palmetto selected multiple demonstration suppliers to provide items in each group of related products. Suppliers could submit bids and have winning bids for one or more groups of items. These suppliers were not guaranteed that they would increase their business or serve a specific number of Medicare beneficiaries. Instead, the demonstration suppliers had to compete for beneficiaries' business. All demonstration suppliers were reimbursed for each competitively bid item provided to beneficiaries at the demonstration fee schedule amounts. The new fee schedules were based on the winning suppliers' bids for items included in the demonstration. Any Medicare supplier that served demonstration locations could provide items not included in the demonstration to beneficiaries.

Evidence from the demonstration suggests that, for the items selected, competition helped set lower payment amounts and resulted in estimated program savings of \$7.5 million. The demonstration's independent evaluators also estimated that beneficiaries saved \$1.9 million. The demonstration provided evidence to health policy experts, including us and the Medicare Payment Advisory Commission, that competitive bidding for medical equipment and supplies could be a viable way for the program to use market forces to set lower payments without significantly affecting beneficiary access.<sup>13</sup>

About a year after the demonstration ended, the MMA required CMS to implement competitive bidding on a large scale and added requirements that suppliers would have to meet to participate in the competitive bidding program. The MMA also required the agency to develop quality standards and for suppliers to be assessed on those standards by accreditation organizations. In addition, the agency had to include a financial and quality assessment of suppliers as part of competitive bidding.

The competitive bidding program was structured to operate much like the demonstration. Suppliers submitted bids, along with other materials specified by CMS. The application required suppliers to submit 3 years of

---

<sup>13</sup>The Medicare Payment Advisory Commission is an independent federal body established by the BBA to advise the U.S. Congress on issues affecting the Medicare program. Medicare Payment Advisory Commission, *Report to the Congress: Variation and Innovation in Medicare*, (Washington, D.C., 2003).

---

financial documents, including income statements, credit reports, and balance sheets. The review of the financial documents was used as part of the criteria for determining which bids to consider. The bidders had to have a valid Medicare supplier billing number and be accredited. Suppliers had to submit bids for one or more groups of items. CMS then evaluated the bids based on demand, capacity, and price and chose bids that were at or under a certain amount.

CMS estimates that the first round of its competitive bidding program will result in payment amounts that overall average 26 percent less than the current fee schedule amounts for the groups of items included, leading to savings for the Medicare program and its beneficiaries. CMS based its estimate on the price points suppliers submitted with their bids, weighted by market area and past utilization of items in each group. The estimated savings differed by groups of items, with the largest savings of 43 percent estimated for mail-order diabetic supplies.

Competitive bidding changes Medicare's relationship with suppliers. Competitive bidding is designed to reduce payments by allowing CMS to choose suppliers based on their bids—a change from the long-standing policy that any qualified provider can participate in the program. The competitive bidding process was designed to limit the number of suppliers to those whose bids were at or under a certain amount while ensuring that enough suppliers were included to meet beneficiary demand. In the demonstration, 50 percent to 55 percent of the suppliers' bids were selected. With few exceptions, only the suppliers whose bids were chosen could be reimbursed by Medicare for competitively bid items provided to beneficiaries residing in the demonstration area.<sup>14</sup>

Furthermore, competitive bidding could help reduce improper payments because it provides CMS with the authority to select suppliers, based in part on new scrutiny of their financial documents and other application materials. In November 2007, CMS estimated that 10.3 percent of Medicare payments made to suppliers of medical equipment and supplies were

---

<sup>14</sup>Transition policies allowed beneficiaries to continue receiving oxygen equipment and supplies and nebulizer drugs from their original suppliers, regardless of whether the suppliers were included in the demonstration. However, the supplier had to accept the new fees set by the demonstration. Transition policies also allowed beneficiaries to maintain pre-existing rental agreements or purchase contracts with their suppliers of enteral nutrition equipment, hospital beds and accessories, and manual wheelchairs and accessories. These suppliers were paid under the normal statewide Medicare fee schedule for the duration of the rental period.

---

improper—more than double the percentage of improper payments to other Medicare providers. Providing additional scrutiny of suppliers gives CMS the opportunity to screen out those whose finances do not indicate that they are stable, legitimate businesses.

---

## Adequate Oversight Is Critical to Ensure Quality and Access

Because of concerns that competitive bidding may prompt suppliers to cut their costs by providing lower-quality items and curtailing services, ensuring quality and access through adequate oversight is critical. Limiting the number of suppliers could potentially affect beneficiaries' access to quality items and services if there are an insufficient number to meet their needs. For some beneficiaries, having a choice of suppliers for some items and services could be important.

In our September 2004 report, we evaluated CMS's competitive bidding demonstration and recommended implementation actions for CMS to consider, including how to ensure access to quality items and services for beneficiaries. We indicated that quality assurance steps could include monitoring beneficiary satisfaction, setting standards for suppliers, providing beneficiaries with a choice of suppliers, and selecting winning bidders based on quality, in addition to the dollar amounts of bids.

The demonstration projects used several approaches for ensuring quality and services for beneficiaries, including monitoring beneficiary satisfaction and applying quality measures as criteria to select winning suppliers. During the demonstration, CMS and Palmetto used full-time, onsite ombudsmen to respond to complaints, concerns, and questions from beneficiaries, suppliers, and others. In addition, to gauge beneficiary satisfaction, independent evaluators of the demonstration fielded two beneficiary surveys by mail—one for oxygen users and another for users of other products in the demonstration. These surveys contained measures of beneficiaries' assessments of their overall satisfaction, access to equipment, and quality of training and service provided by suppliers. Evaluators reported survey results indicating that beneficiaries generally remained satisfied with both the products provided and with their suppliers. The independent evaluators identified some areas for concern, including a decline in the use of portable oxygen among users and the possible shift away from suppliers making home deliveries, which may have indicated that suppliers were visiting new medical equipment users less frequently to provide routine maintenance visits.

---

Because we considered careful monitoring of beneficiaries' experiences essential to ensure that any quality or access problems were identified quickly, we recommended that CMS monitor beneficiary satisfaction with the items and services provided under the new competitive bidding program. As competitive bidding expands and affects larger numbers of beneficiaries, problems such as those identified in the evaluations of the demonstration projects could become magnified. Therefore, continued monitoring of beneficiary satisfaction will be critical to identifying problems with suppliers or with items provided to beneficiaries. When such problems are identified in a timely manner, CMS may develop steps to address them. Such monitoring is important, not just when required by statute, but as part of an ongoing effort to ensure that the Medicare program is serving its beneficiaries effectively.

CMS agreed with our recommendation and stated that the agency would monitor the beneficiary satisfaction with the quality and services provided under the competitive bidding process. CMS also stated in the preamble of its final rule on accreditation of suppliers published August 18, 2006, that it expects that implementing medical equipment and supplies quality standards and accreditation will lead to increased quality of items and services throughout the industry. Furthermore, CMS stated that it plans to provide education to Medicare beneficiaries on the competitive bidding process using approaches such as press releases, fact sheets, and notices.

We will be assessing CMS's implementation of the competitive bidding program. As part of the MMA, we are required to review and report on the program's impact on suppliers and manufacturers and on quality and access of items and services provided to beneficiaries. As part of this review, we have been specifically requested to assess CMS's implementation of the program.

---

## Concluding Observations

We believe that competitive bidding could reduce payments for both the Medicare program and beneficiaries. The independent evaluators estimated savings achieved in the demonstration, and CMS has projected reductions in payment amounts in its competitive bidding program for both Medicare and its beneficiaries. In addition, the new financial standards and accreditation process being implemented in conjunction with the competitive bidding program should help improve the financial viability and quality of medical suppliers providing services to Medicare beneficiaries. But competitive bidding also provides incentives that could affect access to services and lower quality of items and services provided to beneficiaries, which need to be monitored carefully.

---

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or members of the Subcommittee may have.

---

## Contacts and Acknowledgments

For further information regarding this testimony, please contact me at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Sheila Avruch, Assistant Director; Catina Bradley; Kelli Jones; Kevin Milne; Lisa Rogers; and Timothy Walker made contributions to this statement.

---

# Related GAO Products

---

*Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies.* [GAO-07-59](#). Washington, D.C.: January 31, 2007.

*Medicare Durable Medical Equipment: Class III Devices Do Not Warrant a Distinct Annual Payment Update.* [GAO-06-62](#). Washington, D.C.: March 1, 2006.

*Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers.* [GAO-05-656](#). Washington, D.C.: September 22, 2005.

*Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs.* [GAO-05-43](#). Washington, D.C.: November 17, 2004.

*Medicare: Past Experience Can Guide Future Competitive Bidding for Medical Equipment and Supplies.* [GAO-04-765](#). Washington, D.C.: September 7, 2004.

*Medicare: CMS Did Not Control Rising Power Wheelchair Spending.* [GAO-04-716T](#). Washington, D.C.: April 28, 2004.

*Medicare: Challenges Remain in Setting Payments for Medical Equipment and Supplies and Covered Drugs.* [GAO-02-833T](#). Washington, D.C.: June 12, 2002.

*Medicare Payments: Use of Revised "Inherent Reasonableness" Process Generally Appropriate.* [GAO/HEHS-00-79](#). Washington, D.C.: July 5, 2000.

*Medicare: Access to Home Oxygen Largely Unchanged; Closer HCFA Monitoring Needed.* [GAO/HEHS-99-56](#). Washington, D.C.: April 5, 1999.

*Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies.* [GAO/HEHS-98-102](#). Washington, D.C.: May 12, 1998.

*Medicare: Home Oxygen Program Warrants Continued HCFA Attention.* [GAO/HEHS-98-17](#). Washington, D.C.: November 7, 1997.

*Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements.* [GAO/HEHS-95-171](#). Washington, D.C.: August 8, 1995.

---

---

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

---

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

---

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site ([www.gao.gov](http://www.gao.gov)). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to [www.gao.gov](http://www.gao.gov) and select "E-mail Updates."

---

## Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office  
441 G Street NW, Room LM  
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000  
TDD: (202) 512-2537  
Fax: (202) 512-6061

---

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: [www.gao.gov/fraudnet/fraudnet.htm](http://www.gao.gov/fraudnet/fraudnet.htm)

E-mail: [fraudnet@gao.gov](mailto:fraudnet@gao.gov)

Automated answering system: (800) 424-5454 or (202) 512-7470

---

## Congressional Relations

Ralph Dawn, Managing Director, [dawnr@gao.gov](mailto:dawnr@gao.gov), (202) 512-4400  
U.S. Government Accountability Office, 441 G Street NW, Room 7125  
Washington, DC 20548

---

## Public Affairs

Chuck Young, Managing Director, [youngc1@gao.gov](mailto:youngc1@gao.gov), (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, DC 20548