The Medicare DMEPOS Competitive Bidding Program
Myths Versus Facts

MYTH: Competitive bidding has caused a big reduction in utilization of DME products.

FACT: <u>CMS has closely monitored the results of the competitive bidding program since implementation on January 1, 2011, through a real-time claims monitoring system that analyzes the utilization of items in the nine product categories in all competitive bidding areas.</u> For the first year of the program, the real-time claims monitoring and subsequent follow-up has indicated that beneficiaries' continue to have access to necessary and appropriate items and supplies. Moreover, the rate of use of hospital services, emergency room visits, physician visits, and skilled nursing facility care in areas with competitive bidding has remained consistent with the patterns and trends seen throughout the rest of the country. CMS's monitoring revealed larger declines in competitive bidding areas as compared to non-competitive bidding areas in the use of two products — mail-order diabetes test strips and continuous positive airway pressure (CPAP) supplies. In response to these declines, CMS initiated calls to users of these supplies in the nine competitive areas. The calls revealed that in virtually every case, the beneficiary reported having more than enough supplies on hand, often multiple months' worth, and therefore did not need to obtain additional supplies when the program began.

MYTH: The low payments made under competitive bidding will force manufacturers to provide only low quality equipment.

FACT: <u>Medicare requires that all suppliers in the program meet applicable state licensure requirements, meet strict quality and business standards, and be accredited by a national accreditation organization.</u> Quality product-specific service standards include intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver, and follow-up service. Business standards focus on administration, financial management, human resource management, consumer services, performance management, product safety, and information management. The quality standards ensure that Medicare beneficiaries only receive products as ordered by their physician. Products must meet applicable quality standards and be provided by qualified professionals.

The program includes an anti-discrimination policy, meaning that suppliers have to offer their Medicare beneficiaries the same products they offer their other customers. This applies to all product categories.

All items furnished under the competitive bidding program must meet applicable Food and Drug Administration requirements, including regulation and medical device effectiveness and safety standards. CMS believes beneficiaries are receiving quality items under the competitive bidding program because the agency has received few inquiries and complaints about the program and because the real-time monitoring shows that there have been no changes in beneficiary health status outcomes resulting from the competitive bidding program.

MYTH: Competitive bidding will lead to less competition in the market, and will hurt the long-term sustainability of the DME benefit due to fewer suppliers wanting to participate.

FACT: **The competitive bidding program includes numerous provisions to ensure a robust, competitive market.** For example, CMS selects more than enough suppliers to meet demand. As a general rule for contract supplier selection purposes, CMS does not credit more than 20 percent of the total Medicare demand for a product category in a competitive bidding area to any one supplier, meaning at least five suppliers serve most product categories in most areas (most areas have significantly more suppliers). For example, in the Bakersfield-Delano, CA competitive bidding area, 23 bidders were offered contracts for wheelchairs and scooters (34 total locations) and 22 bidders were offered contracts for CPAP supplies (35 total locations).

In addition, CMS has taken specific steps to ensure that small suppliers can be considered for participation in the competitive bidding program. These steps include offering small suppliers the opportunity to form networks, a small supplier target, and not requiring suppliers to submit bids for all product categories.

MYTH: CMS has been very secretive about this process, and there is no transparency around how they set the bids and how they run the program.

FACT: **CMS has been as open and transparent as the law allows throughout the entire development and implementation of the program.** CMS held numerous Program Oversight & Advisory Committee (PAOC) meetings and open door forums, went through notice and comment rulemaking, and released information through listserv messages and ongoing educational and outreach programs.

CMS has been very forthcoming with how the program was designed, how the single payment amounts are set, and how each supplier and their bid is evaluated. However, CMS is unable to release bid data as that information is proprietary and confidential.

MYTH: Because CMS didn't require bids to be binding, we've heard of many fly-by-night companies that have submitted really low suicide bids – that's why the single payment rates are so low and any reputable supplier can't afford to provide products at such low prices.

FACT: ***Binding bids*** **– Though CMS does not have authority under this program to require suppliers to submit a binding bid, 92 percent of suppliers offered contracts in the Round 1 Rebid accepted them.** There has been no indication of any beneficiary access problems, and CMS has not had to add any new suppliers to meet demand. Furthermore, CMS does not feel it would be in the best interest of the beneficiary to force a supplier to provide services in a patient's home when the supplier does not want to participate.

Suicide bids **– CMS has a robust screening process in place to make sure that all bids are bona fide (in other words, realistic).** CMS also requests additional documentation from suppliers for certain bids if the agency identifies a bid as potentially non-bona fide, and CMS rejects any bids that do not pass this evaluation.

MYTH: CMS inappropriately manipulated provider capacity when calculating the single payment amounts, and that's why the single payment amounts don't really reflect true market prices – they are much too low.

FACT: CMS calculates the projected beneficiary demand for each product category in each competitive bidding area using historical claims data, plus trending factors.

To evaluate the capacity of a supplier that plans to expand its capacity (i.e., total estimated capacity exceeds historic claims in the competitive bidding area or product category), CMS looks at the expansion plan as well as the hardcopy financial documents to determine the ability of that supplier to furnish its estimated capacity. If a supplier is new to an area, new to a product category, or submits estimated capacity that represents substantial growth over current levels, CMS may conduct a more detailed evaluation of that supplier's expansion plan to verify the supplier's ability to provide items and services in the competitive bidding area on day one of the contract period. If a bidder's financial health and expansion plan do not support the supplier's estimated capacity, CMS will adjust the capacity to the supplier's historic level. In addition, to help ensure that there are multiple suppliers for all items in each competitive bidding area, each bidder's estimated capacity, for purposes of bid evaluation only is limited to 20 percent of the expected beneficiary demand for a product category in a competitive bidding area. This policy ensures that multiple contract suppliers for each product category are selected and that more than enough contract suppliers are selected to meet demand for items and services in the area. This adjustment does not limit the number of items a supplier could furnish if awarded a contract. This adjustment does not apply to the national mail-order competition.

MYTH: Why would CMS choose to use the median bid instead of the maximum bid to set the single payment amount? It's unfair to suppliers to ask half of them to take a payment rate less than what they can afford. This will destroy the market.

FACT: **Under the program, the single payment amount for an item furnished under a competitive bidding program is equal to the median of the bids submitted for that item by suppliers whose composite bids for the product category that includes the item are equal to or below the pivotal bid for that product category.** If there is an even number of bids, the single payment amount for the item is equal to the average of the two middle bids. In the proposed rule published May 1, 2006, CMS discussed various approaches the agency considered for setting the single payment amounts, including taking the maximum winning bid for each item. Using the maximum bid would have led to payment amounts that were higher than necessary because some suppliers were willing to provide the items at a lower price. CMS believes that setting the single payment amount at the median of the bids results in what the agency considers a reasonable payment amount based on prices available in the marketplace. This methodology reduces the effect of excessively high or low bids and helps to ensure savings for the Medicare program. Accordingly, CMS believes it is consistent with the intent of competitive bidding.