



# MEDICARE COMPETITIVE ACQUISITION OMBUDSMAN

Medicare Durable Medical Equipment, Prosthetics,  
Orthotics, and Supplies Competitive Bidding Program

**2011 Report to Congress**  
Centers for Medicare & Medicaid Services





## **MEDICARE COMPETITIVE ACQUISITION OMBUDSMAN**

**MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS,  
ORTHOTICS, AND SUPPLIES COMPETITIVE BIDDING PROGRAM**

2011 REPORT TO CONGRESS  
CENTERS FOR MEDICARE & MEDICAID SERVICES

TANGITA DARAMOLA  
MEDICARE COMPETITIVE ACQUISITION OMBUDSMAN



## TABLE OF CONTENTS

<b>LIST OF ACRONYMS AND ABBREVIATIONS .....</b>	<b>ii</b>
<b>MESSAGE FROM THE COMPETITIVE ACQUISITION OMBUDSMAN .....</b>	<b>iii</b>
<b>CAO MISSION, VISION, AND ORGANIZATION .....</b>	<b>iv</b>
<b>DMEPOS COMPETITIVE BIDDING PROGRAM BACKGROUND .....</b>	<b>v</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>1</b>
Introduction .....	1
Key Accomplishments .....	1
<b>SUPPORTING THE DMEPOS COMPETITIVE BIDDING PROGRAM .....</b>	<b>2</b>
Introduction .....	2
Supporting High Quality Customer Service .....	2
Engaging Stakeholders .....	3
Sharing Research Findings .....	5
<b>COMPETITIVE BIDDING PROGRAM INQUIRY AND COMPLAINT TRENDS .....</b>	<b>7</b>
Introduction .....	7
Inquiry and Complaint Data .....	7
Annual Inquiry and Complaint Trends .....	8
<b>RESPONSE TO BENEFICIARY AND SUPPLIER ISSUES .....</b>	<b>14</b>
Introduction .....	14
Priority Issues in 2011 .....	14
Standard Power Wheelchair Repairs .....	16
CPAP Device Medical Necessity Documentation .....	17
Mail-Order Diabetes Supplies .....	18
Other Issues in 2011 .....	19
<b>LOOKING AHEAD .....</b>	<b>21</b>
CAO Objectives for 2012 .....	21
Suggestions to Improve Beneficiary and Supplier Experiences .....	22



## LIST OF ACRONYMS AND ABBREVIATIONS

Acronym	Term
Act	Social Security Act
ADA	American Diabetes Association
CAO	Competitive Acquisition Ombudsman
CBIC	Competitive Bidding Implementation Contractor
CM	Center for Medicare
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CSC	Customer Service Component
CSR	Customer Service Representative
DHHS	Department of Health and Human Services
HIPAA	Health Information Portability and Accountability Act of 1996
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
LCD	Local Coverage Determination
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA	Metropolitan Statistical Area
NCD	National Coverage Determination
OC	Office of Communications
OMO	Office of the Medicare Ombudsman
OPE	Office of Public Engagement
PAOC	Program Advisory and Oversight Committee
RO	Regional Office
SHIP	State Health Insurance Assistance Program
SME	Subject Matter Expert



## MESSAGE FROM THE COMPETITIVE ACQUISITION OMBUDSMAN



I am pleased to present the Competitive Acquisition Ombudsman (CAO) 2011 Annual Report to Congress as required by section 154(b)(3) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which amended section 1847 of the Social Security Act (the Act). The CAO is a statutorily established ombudsman office within the Centers for Medicare & Medicaid Services (CMS). The CAO is charged with responding to inquiries and complaints from suppliers and individuals about the application of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. This Program went into effect on January 1, 2011 for more than 700,000 beneficiaries who use DMEPOS, with the goal of changing the amount Medicare pays for DMEPOS items and services while maintaining access and quality. The CAO plays a vital role in ensuring that Agency processes respond effectively to inquiries and complaints about the Program and notifying Agency leadership about potential systemic issues that may affect beneficiaries' access to quality DMEPOS items and services.

In 2011, multiple CMS components worked to launch the Program in nine Metropolitan Statistical Areas (MSAs). As a result, a high number of beneficiaries began receiving DMEPOS items and services at competitively bid prices that, data show, produce substantial cost savings for both Medicare and beneficiaries compared to fee schedule prices. In this first year, Medicare saved 42 percent compared to 2010 expenditures for these items in these areas and beneficiaries had lower cost sharing responsibilities.

During the year, the CAO worked with other Agency components to implement systems for responding to Program inquiries and complaints, monitoring trends in Program data and stakeholder feedback, and reporting potential systemic issues to CMS leadership. Of these, reporting potential systemic issues was our highest priority because systemic issues may reflect a gap in Program processes, which could negatively affect multiple stakeholders. When a supplier or beneficiary submitted an inquiry or complaint regarding the Program, we helped address it by working with CMS policy components, meeting with stakeholders, and reviewing inquiry and complaint data. We also collaborated within CMS to update Agency Web pages—making information about the Competitive Bidding Program as accessible as possible.

This Report covers the 2011 calendar year and describes Program inquiry and complaint data from CMS' customer service components (CSCs), and responses to priority issues that were identified in 2011. It also provides suggestions for improving supplier and beneficiary experiences under the Program as it goes forward.

Despite CMS' success launching the Program in 2011, there is much to be done as we prepare for the next phase. When Round Two begins, beneficiaries with Original Medicare who live in or travel to areas that are covered by the Program and need competitively bid items will need to use contract suppliers for Medicare to pay unless an exception applies. Transitioning beneficiaries to DMEPOS contract suppliers requires CMS components to assess their existing processes to ensure that they will be prepared to interface smoothly as the Program expands. The CAO is currently supporting Agency efforts to prepare beneficiaries and suppliers for Round Two by facilitating demographic research, engaging stakeholders in discussions about the Program, and helping to enhance communication strategies for reaching vulnerable and hard-to-reach beneficiaries with Program information.

We remain committed to providing quality responses to inquiries and complaints about the Program and helping to ensure that suppliers and individuals have access to information about it. Moving forward, we will continue collaborating within CMS to identify and address any potential systemic issues that may emerge as the DMEPOS Competitive Bidding Program moves toward Round Two.

---

Tangita Daramola  
Medicare Competitive Acquisition Ombudsman



## CAO MISSION, VISION, AND ORGANIZATION

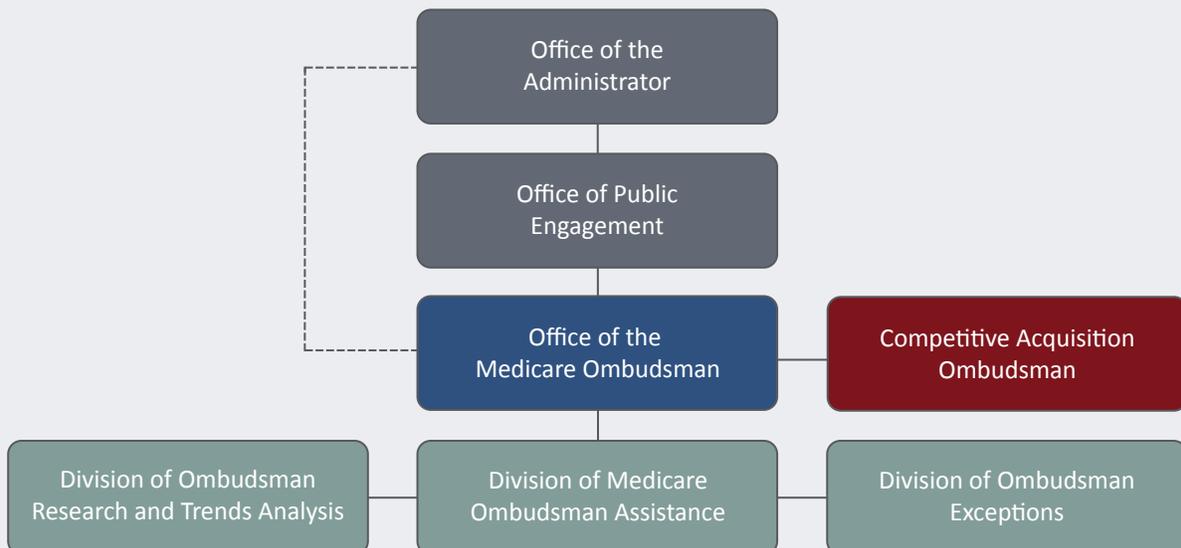
The CAO’s mission is to provide quality responses to suppliers and individuals who are affected by the DMEPOS Competitive Bidding Program and unbiased reporting to Congress. As an ombudsman, the CAO also facilitates Program improvements by working with other CMS components to identify potential systemic issues. These groups collaborate to monitor and report on supplier and beneficiary experiences with the DMEPOS Competitive Bidding Program and help CMS make improvements.

The CAO is organized within the Office of the Medicare Ombudsman (OMO) at CMS (see Figure 1). The CAO is charged with responding to inquiries and complaints from DMEPOS suppliers, beneficiaries, and other individuals about the application of the Competitive Bidding Program. The OMO handles inquiries and complaints about all other aspects of the Medicare Program.

**Mission:**  
*Provide quality responses to DMEPOS suppliers and individuals and unbiased reporting to Congress.*

**Vision:**  
*Ensure timely responses to suppliers’ and individuals’ inquiries and complaints and gather and report inquiry and complaint data to the Agency that can be used to improve the Competitive Bidding Program.*

**Figure 1. Organization of the CAO within CMS**





## DMEPOS COMPETITIVE BIDDING PROGRAM BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1847 of the Act to require the Secretary of the Department of Health and Human Services (DHHS) to establish and implement the Medicare Competitive Bidding Program for DMEPOS under which competitive bidding areas are established throughout the United States for certain items and services. Under the Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in specified areas. The Program will replace Medicare's existing, outdated, and excessive fee schedule amounts with market-based prices for certain items and services. The Patient Protection and Affordable Care Act of 2010 further expanded the Program.

In its first year of implementation, the Competitive Bidding Program saved the Medicare Fee-For-Service program approximately \$202 million.<sup>1</sup> This represents an expenditure reduction of over 42 percent in the nine markets participating in year one.<sup>1</sup> Estimates indicate that the Program will save Medicare, seniors, and taxpayers \$42.8 billion over 10 years.<sup>2</sup>

The Program was designed to both reduce the amount Medicare and beneficiaries pay for DMEPOS items and to preserve beneficiary access to high quality products and services. The CAO, along with many other CMS components, help ensure that this second goal is met.

The MMA originally required the Program to be phased in with the first supplier competitions occurring in 2007 in 10 of the largest Metropolitan Statistical Areas (MSAs). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the Program and made

certain limited changes, one of which called for CMS to conduct the first bid competitions (originally held in 2007) again in 2009. Thus, the first phase of the Program that was conducted in 2007 is referred to as Round One, while the second competition conducted after MIPPA temporarily delayed the Program is referred to as the Round One Rebid.

***The Program was designed to both reduce the amount Medicare and beneficiaries pay for DMEPOS items and to preserve beneficiary access to high quality products and services.***

The Round One Rebid contracts and prices became effective in nine areas on January 1, 2011. As required by MIPPA, CMS also began the competition for the next phase of the Program (Round Two) in 2011. In August of that year, CMS started a supplier awareness program for Round Two and announced the areas and products included in it. On November 30, 2011, CMS announced the detailed Round Two bidding schedule and began a bidder education program. These efforts helped suppliers prepare to register starting in early December 2011 and submit their bids beginning in late January of 2012. The Agency also began preparations for a national mail-order Competition for diabetic testing supplies on the same schedule as Round Two.

While the Agency implemented the Round One Rebid and laid groundwork for Round Two, many CMS components and the CAO focused on helping suppliers and beneficiaries transition successfully into the Program.

<sup>1</sup> United States Government Accountability Office Report to Congressional Committees. MEDICARE: Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid. Publication number GAO-12-693. May 2012; p. 55.

<sup>2</sup> Department of Health and Human Services, Center for Medicare. Competitive Bidding Update—One Year Implementation Update. April 17, 2012; p.1. Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf>



## EXECUTIVE SUMMARY

### Introduction

On January 1, 2011, CMS implemented the Round One Rebid phase of the DMEPOS Competitive Bidding Program. New supplier contracts and prices became effective and CMS' customer service components (CSCs), including the CAO, began responding to inquiries and complaints from beneficiaries and other stakeholders.

***Throughout 2011, the CAO used its unique position to monitor and report supplier and beneficiary experiences with the DMEPOS Competitive Bidding Program and to recommend possible improvements.***

More than 700,000 beneficiaries who use DMEPOS items live in Round One Rebid areas and, as with any new or changing program, it was likely that some might have questions during the transitional period. In 2011, the majority of inquiries about the Program concerned the need for finding or understanding Program information (69,392 of 127,466 or 54% of total inquiries). This represented less than one percent of total call volume at the 1-800-MEDICARE call center. Suppliers most often asked for clarification of Program policies and procedures. Beneficiaries and their advocates most often asked for help locating contract suppliers and for general information about the Program.

While Program inquiries represented only a small fraction of all calls to CSCs, they were highly important to the CAO because each represented a DMEPOS Competitive Bidding stakeholder.

### Key Accomplishments

Throughout 2011, the CAO used five strategies to fulfill its mission: collecting and reporting data, managing issues, engaging stakeholders, facilitating customer service component training, and analyzing research.

Key accomplishments in these areas included:

- **Implementing a data collection and reporting mechanism** for Program inquiries and complaints.
- **Identifying and raising issues to leadership**, such as concerns beneficiaries and/or suppliers had with:
  - o Repairing standard power wheelchairs;
  - o Obtaining required medical necessity documentation for Continuous Positive Airway Pressure (CPAP) devices and supplies;
  - o Identifying contract suppliers that offered specific mail-order diabetes supply brands; and
  - o Meeting Form C Quarterly Report deadlines.<sup>3</sup>
- **Conducting a Partner Feedback Forum and Supplier Listening Sessions** to hear about the Program directly from stakeholders.
- **Collaborating with other CMS components to complete caseworker trainings** that began in 2010 and develop training for Round Two which will expand the Program to 91 additional MSAs.
- **Sharing previous research results within CMS and beginning new research** to support Round Two plans for refining the inquiry and complaint response network such as:
  - o Providing a report to support Agency calculations determining how many and where Competitive Bidding Implementation Contractor (CBIC) liaisons should be placed for Round Two; and
  - o Beginning a demographic analysis of claims data from all Round Two MSAs titled, *DMEPOS Users and Utilization in Round Two CBAs*, to better anticipate inquiries and complaints that might arise and support customer service segment efforts to inform beneficiaries about the Program.

<sup>3</sup> The Medicare DMEPOS Competitive Bidding Program Form C is a report that each contract supplier must complete each quarter to update their product information for the Supplier Directory on the [www.medicare.gov](http://www.medicare.gov) website. The Supplier Directory is a useful marketing tool that beneficiaries, their caregivers, and the 1-800-MEDICARE customer service representatives use to identify contract suppliers that furnish specific brands of DMEPOS products.



## SUPPORTING THE DMEPOS COMPETITIVE BIDDING PROGRAM

### Introduction

The CAO conducts many activities to accomplish its mission of providing quality responses to suppliers and individuals who are covered by the DMEPOS Competitive Bidding Program. These activities also enhance the overall Program by:

- Ensuring that CMS is aware of potential implementation challenges;
- Supporting CMS' inquiry and complaint response network;
- Supporting training for Customer Service Components (CSCs);
- Engaging stakeholders in discussions about the Program;
- Providing a system for unifying and reporting inquiry and complaint data from multiple sources; and
- Sharing research within the Agency on Program beneficiaries' demographics obtained through Medicare claims data and perceptions obtained through the inquiry and complaint process.

### Supporting High Quality Customer Service

In the Fall of 2011, CMS issued a new contract task order to develop and implement a Competitive Bidding Program Training and Communication Support Initiative. This effort aimed to provide high quality Program information, training, and outreach support to CSCs, and to enhance the customer service culture in preparation for Round Two.

The CAO and staff from the Office of the Medicare Ombudsman (OMO) collaborated to establish a Steering Committee with members from the Center for Medicare (CM), CMS Regional Offices (ROs), and Office of Communications (OC). Establishing this Committee engaged key CMS stakeholders as advisors in developing the Initiative. The project team (CAO and OMO staff) and Committee members shared data and outreach plans to ensure

consistent, timely messaging across all training, communication, and outreach materials. They also identified future training targets (who might be trained, how trainings might take place, and what content might be included) and worked to ensure that reviews and clearance of Program materials were coordinated.

***The CAO conducts many activities to accomplish its mission of providing quality responses to suppliers and individuals who are covered by the DMEPOS Competitive Bidding Program.***

The Committee supported the project team's proposal to conduct a training needs assessment. The assessment drew additional input from one-on-one interviews and group feedback sessions with relevant CMS staff, State Health Insurance Assistance Program (SHIP) directors, and SHIP liaisons in the ROs. This will help the Committee assess whether and when additional Program resource materials may be needed.

The project team's training recommendations and findings are scheduled to be completed in early 2012 and will be discussed in the next CAO Report to Congress. The project team will propose a list of potential training topics, recommended training modalities, and timelines for product development and delivery, and provide a complete inventory of existing Program educational materials. The latter will be used to determine if any existing materials need updating and if new materials should be developed to support training and education for Round Two of the Program.

All of these activities supported CMS' broader efforts to assess and design its Round Two education and training strategy. Part of this strategy will be to post a collection of updated Program training and outreach



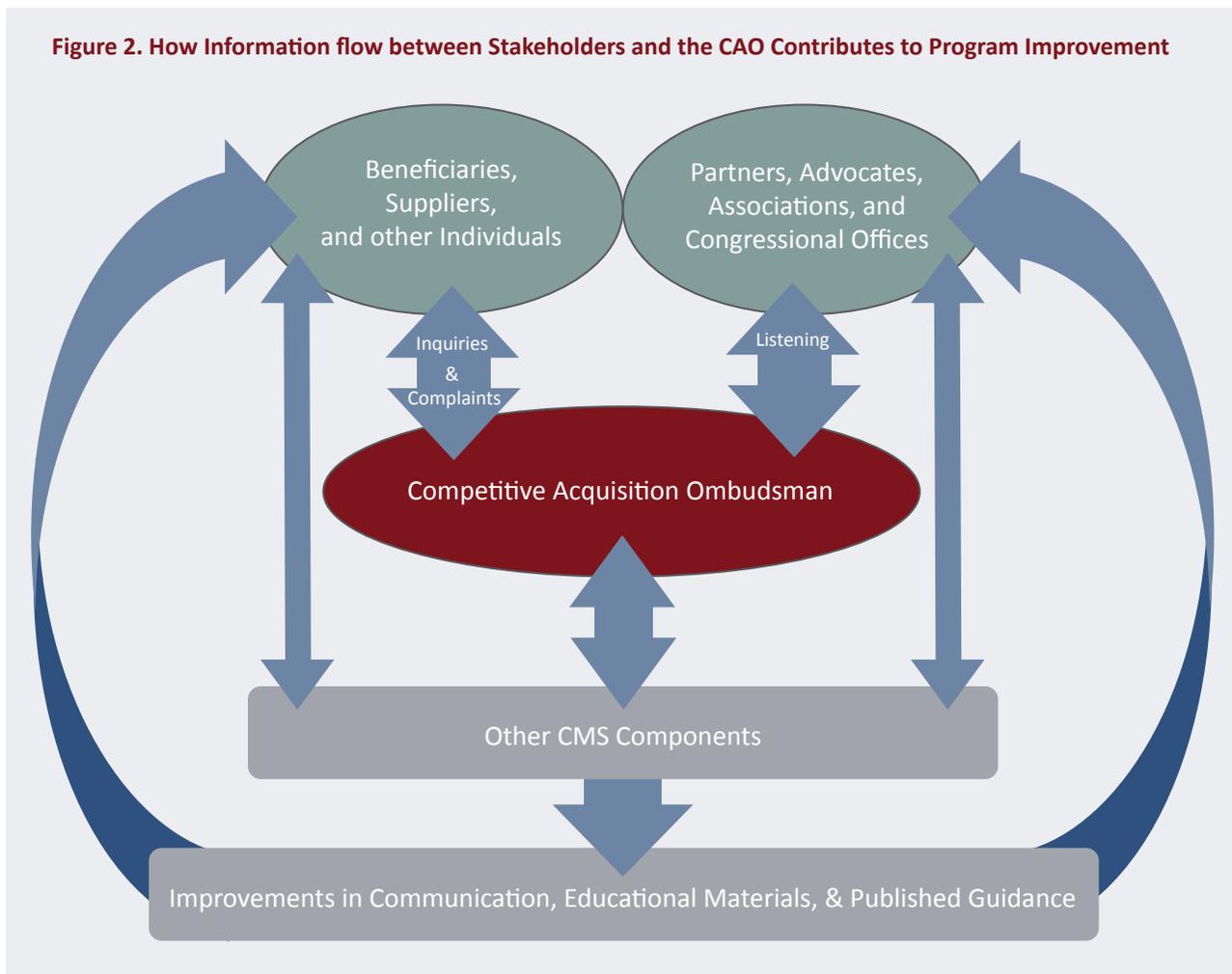
materials to an internal CMS Web site so that CSC staff can access the information in ‘real time’ as needed. This Web-based approach will allow CMS to extend Program trainings to a wider audience and provide a mechanism for updating educational materials to reflect the most current Program policies.

The CAO continues collaborating within the Agency on education and training efforts related to communicating Competitive Bidding Program information.

### Engaging Stakeholders

Many CMS areas including the 1-800-MEDICARE call center, CBIC, and ROs handle Program inquiries and complaints from external stakeholders. As an ombudsman, the CAO maintains open lines of communication with Program stakeholders and meets with individuals and organizations to explore their concerns and options for resolving them. In short, the CAO provides a channel for two-way communication about the Program among CMS components and between the Agency and outside stakeholders (see Figure 2).

**Figure 2. How Information flow between Stakeholders and the CAO Contributes to Program Improvement**





In 2011, the CAO built relationships with external stakeholders by listening to their experiences, questions, and concerns about the Program and providing information about it. To do this, the CAO held three Supplier Listening Sessions (January 11, June 1, and October 25, 2011) and a Partner Feedback Forum (March 9, 2011) (see Figure 3). At these events, suppliers and beneficiary advocates raised questions and complaints directly to the CAO. They also provided feedback on their experiences with the Program. Based in part on this feedback, the Agency responded by clarifying specific Program policies that participants had misunderstood. These clarifications are discussed in detail in the *Response to Beneficiary and Supplier Issues* section of this Report.

The CAO attended the joint COPD7USA Conference and Second National COPD Conference for beneficiary advocacy groups in Arlington, Virginia on December 4, 2011. At this conference, the CAO spoke and answered questions about the

Competitive Bidding Program in general and policies for CPAP devices and oxygen equipment in particular. In addition, one of the groups attending asked for help in getting more Program information to its members. In response, the CAO directed this organization to available Program information on relevant topics that could be used in communications to its members. This group also helped the CAO identify online ‘bulletin boards’ where discussion topics could be posted to stimulate feedback on the Program from beneficiaries who use oxygen equipment.

On the supplier side, the CAO attended Medtrade Fall in Atlanta, Georgia on October 25, 2011. This large annual meeting of DMEPOS suppliers was an opportunity for the CAO to hear their questions and concerns about other Program policies. In addition to large meetings with suppliers and beneficiary advocates, several suppliers and beneficiary advocacy groups requested smaller meetings with the CAO to discuss their particular concerns. Figure 3 illustrates CAO engagement with external Program stakeholders throughout 2011.

**Figure 3. CAO Meetings with Suppliers and Beneficiary Advocates in 2011**





The CAO also made a presentation to the Program Advisory and Oversight Committee (PAOC) meeting on April 5, 2011, to provide an update on its activities and answer questions about Program inquiries and complaints received to date. The Secretary is statutorily required to establish a PAOC to provide advice to the Secretary on certain issues, including implementation of the DMEPOS Competitive Bidding Program. Committee members represent beneficiaries and both large and small DMEPOS suppliers and manufacturers. Members of the public are also invited to participate in PAOC meetings. In addition to meeting formally with stakeholders, the CAO had many informal conversations in person, by phone, and via email with suppliers and individuals who had questions about the Program.

### Sharing Research Findings

Previous Agency experience highlights the importance of identifying individuals who will be affected by any new program and making every effort to ensure they are well informed before changes take effect. Although a rise in call volume is normal and expected during program transitions, targeted educational outreach efforts are crucial to keep the number of inquiries and complaints as low as possible.

Before beginning the Round One Rebid, CMS identified DMEPOS beneficiaries in the first nine MSAs and the products they used to prepare for their potential questions. The CAO contributed to these efforts by overseeing a demographic study which found that 84% of beneficiaries affected by the first Program phase were 65 years old or older, 58% were women, 23% were minorities, and 26% used more than one Competitive Bidding product. This study also revealed that mail-order diabetes supplies were the most widely used Program product.

A separate, focus group study documented the attitudes and perceptions of beneficiaries, caregivers, and referral agents in Round One Rebid areas. (The term 'referral agents' includes physicians and other healthcare providers, key administrative

personnel in their offices, hospital discharge planners, social workers, and pharmacists who may direct beneficiaries to suppliers of the DMEPOS items and services they need.) This study, which was conducted before the Program began, provided useful insights into how beneficiaries obtain DMEPOS items. For example, it found that most beneficiaries relied on referral agents to direct them to DMEPOS suppliers, and that most referral agents got their information about obtaining DMEPOS from DMEPOS suppliers. This study is discussed in greater detail in the CAO's 2010 Report to Congress that can be found on the [www.cms.gov](http://www.cms.gov) website.

In February 2011, the CAO widely shared the final study reports within CMS. The findings helped the Agency better understand the characteristics and needs of DMEPOS beneficiaries in the Round One Rebid MSAs. They also shed light on respondents' perceptions about the Program before it was implemented and gave the Agency insight into the types of inquiries and complaints that might have arisen when the Program began.

### ***The findings helped the Agency better understand the characteristics and needs of DMEPOS beneficiaries in the Round One Rebid MSAs.***

The CAO also commissioned a study to strategically assess the placement of Competitive Bidding Implementation Contractor (CBIC) liaisons in preparation for the Program's Round Two expansion. These customer service liaisons are an essential component of the Agency's inquiry and response network. The analysis that was produced provided options for the most efficient way to disperse CBIC liaisons across the 100 total MSAs in 2013. This study was presented to CM in May 2011 for review.

In addition, the CAO began planning a new study in 2011. This study, titled *DMEPOS Users and Utilization in Round Two CBAs*, analyzes the demographics of beneficiaries in Round Two MSAs who have claims for competitively bid items. Findings are expected to foster a better understanding of the characteristics and needs of



beneficiaries and provide insight into the types of inquiries and complaints that might arise as the Program moves forward. The target date for reporting findings from these studies is early 2013.

In advance of results from the demographic study, the CAO drew a preliminary picture of beneficiaries in the Round Two MSAs using data from the United States Census Bureau. The data indicated that there are many minority, vulnerable, and hard-to-reach beneficiaries in these areas including people who speak English as a second language, have low incomes, receive healthcare at an emergency department, are elderly, have vision, hearing, or mobility impairments, or are socially isolated. As is the case with all Medicare initiatives, it is important that these groups are well-informed about the Program before Round Two begins to ensure they have uninterrupted access to their DMEPOS items and to minimize the number of inquiries and complaints these groups may otherwise have.

The CAO shared this information with CMS outreach components, including the Office of Minority Health and Partner Relations Group. Staff from these groups met with the CAO to discuss where minority, vulnerable, and hard-to-reach beneficiaries affected by the Program are concentrated, the most effective ways to reach them, and how to prepare to respond to inquiries and complaints.

The CAO continues meeting with other CMS components to share Program information and to ensure communications include the following key information and important messages:

- What beneficiaries should know about the Competitive Bidding Program;
- That all DMEPOS suppliers who are awarded a contract under the Program must meet CMS quality standards, be accredited and licensed for the product(s) they provide, and meet financial standards; and
- That beneficiaries should call 1-800-MEDICARE if they have any questions about the Program or if they have any concerns about their DMEPOS products.



## COMPETITIVE BIDDING PROGRAM INQUIRY AND COMPLAINT TRENDS

### Introduction

DMEPOS Competitive Bidding Program inquiry and complaint data are collected by multiple CMS areas including the 1-800-MEDICARE call center, CBIC, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and ROs. The CAO works with these groups to collect their data each quarter and reconcile it into a single report. These brief, quarterly reports provide CMS with a broad view of inquiry and complaint trends across the Program and help identify any potential systemic problems.

***The CAO pulls together Competitive Bidding Program inquiry and complaint data from multiple CMS areas and produces unified quarterly reports to give the Agency a succinct overview of all inquiries and complaints received.***

Compiling and analyzing inquiry and complaint data supports the CAO’s core functions (see Table 1). When an inquiry or complaint trend appears, the

CAO discusses it with CMS components, identifies and researches the central issue, and reports it to Agency leadership. This fosters a broad perspective on the Program within CMS and a better understanding of Program policies and processes among stakeholders.

### Inquiry and Complaint Data

In the first quarter of 2011, 1-800-MEDICARE staff sent their Program inquiry and complaint data to the CAO for analysis and reporting. By the end of the second quarter, all four CMS areas that receive Program inquiries and complaints (1-800-MEDICARE, CBIC, DME MACs, and ROs) were sending their Program data to the CAO.

To accurately compile data from multiple sources, the CAO had to define DMEPOS Competitive Bidding Program ‘inquiries’ and ‘complaints.’ It is important that the definitions are as objective as possible to ensure that these terms are used consistently by staff across the multiple CMS areas that handle Program inquiries and complaints. Customer service components (CSCs) began working with the CAO on this task in 2010 to ensure that contacts (phone calls, emails, and in-person) received about the Program were consistently categorized.

Table 1. CAO Core Functions

Function	Description
<b>Respond</b>	Respond to suppliers’ and individuals’ inquiries and complaints about the DMEPOS Competitive Bidding Program.
<b>Communicate</b>	Provide an Annual Report to Congress that details CAO activities, identifies potential systemic issues, and makes appropriate recommendations for improvements. Maintain a Web site with information on inquiry and complaint processes.
<b>Manage Risk</b>	Work with Agency components to address related inquiries and complaints.
<b>Facilitate</b>	Facilitate understanding of the Program by communicating regularly with stakeholders and raising their concerns about the application of the Program to the appropriate Agency component.



During 2011, the CAO and CSCs used the following criteria to classify Program contacts as either ‘inquiries’ or ‘complaints.’

- Program inquiries were:
  - Satisfied by the initial Medicare CSC that responded to the contact; and
  - Resolved by guiding the person to existing Program resources or processes.
- Program complaints were:
  - Expressing dissatisfaction;
  - Not satisfied by the initial Medicare CSC that responded to the contact;
  - Not resolved by guiding the person to existing Program resources or processes; and
  - Transferred to another CMS component for resolution.

Regardless of whether a contact is classified as an ‘inquiry’ or a ‘complaint,’ it is tracked by CMS and monitored by the CAO until it is fully resolved. When the CAO reported Program inquiry and complaint data from the first quarter of 2011 (57,530 inquiries and 45 complaints), suppliers thought that the number of Program complaints was too low and expressed their belief that the way ‘complaints’ were defined had caused under-counting. The CAO responded by beginning discussions with suppliers, the CSCs, and Agency leadership about this issue and how the definition might be revised.

It was concluded that the definition of complaints should incorporate all inquiries that cannot be resolved by the initial customer service contact. Because these inquiries cannot be resolved by the customer contact center, they are transferred to areas in the CMS environment where casework is done. CMS also monitors inquiries that are not transferred by reviewing weekly, monthly, and quarterly trends (increases and decreases). By conducting casework and tracking trends, CMS identifies areas for further investigation. Thus, there is no need to change the current definitions.

As Agency leadership explained during the PAOC meeting on April 5, 2011, CMS understands that DMEPOS suppliers are often the initial point of contact for individuals with complaints and, thus,

not all complaints about the Program may be submitted through its customer service channels. Throughout 2011, the Agency asked suppliers to submit specific information about any complaints they were aware of that CMS customer service staff may not have received but none were submitted.

In addition to CMS’ several customer service channels, the CAO held forums during the year that were specifically designed for suppliers and beneficiaries to raise their inquiries and complaints about the Program (see *Engaging Stakeholders*). At these events, suppliers and beneficiary advocates spoke directly to the CAO about their questions and concerns. These in-person conversations with stakeholders added context to CSC data and depth to internal Agency discussions about inquiry and complaint trends (see *Response to Beneficiary and Supplier Issues*).

### Annual Inquiry and Complaint Trends

Overall, 2011 inquiry data indicated that Competitive Bidding Program implementation was smooth and Program inquiries were a small fraction of all inquiries made to 1-800-MEDICARE in 2011 (0.6% of 26,101,770 calls). Inquiries gradually waned over the course of the year after rising during the initial stages of Program implementation (see Figure 4). As with all Medicare initiatives, educational materials emphasized that anyone with questions about the Program should call 1-800-MEDICARE and this customer service component commonly experiences a rise in calls when new programs begin. As suppliers and beneficiaries became more familiar with the Program’s processes, calls about it declined. The number of Program inquiries to 1-800-MEDICARE fell from 19,887 in January to 4,501 in December (see Figure 4).

Overall, a total of 151 complaints about the Program were received by 1-800-MEDICARE in 2011. Like inquiries, complaints fell over the course of the year. Forty-three complaints were received in the first quarter (January–March), and that number rose to 73 in the second quarter (April–June). In the third quarter (July–September), the number of complaints fell to 29 and the fourth quarter (October–December) saw only 6.



By the end of the year, we were able to break complaints down into categories to better identify any potential trends. Of the 6 Program complaints received during the fourth quarter of 2011, 3 were about diabetes supplies, 2 were about wheelchairs, and 1 regarded CPAP devices. Furthermore, the majority (5) of these complaints concerned suppliers while 1 was about equipment. Going forward, the CAO will provide complaint category details in its regular quarterly fact sheets.

Unfortunately, this information is not available for quarters 1 through 3 of 2011.

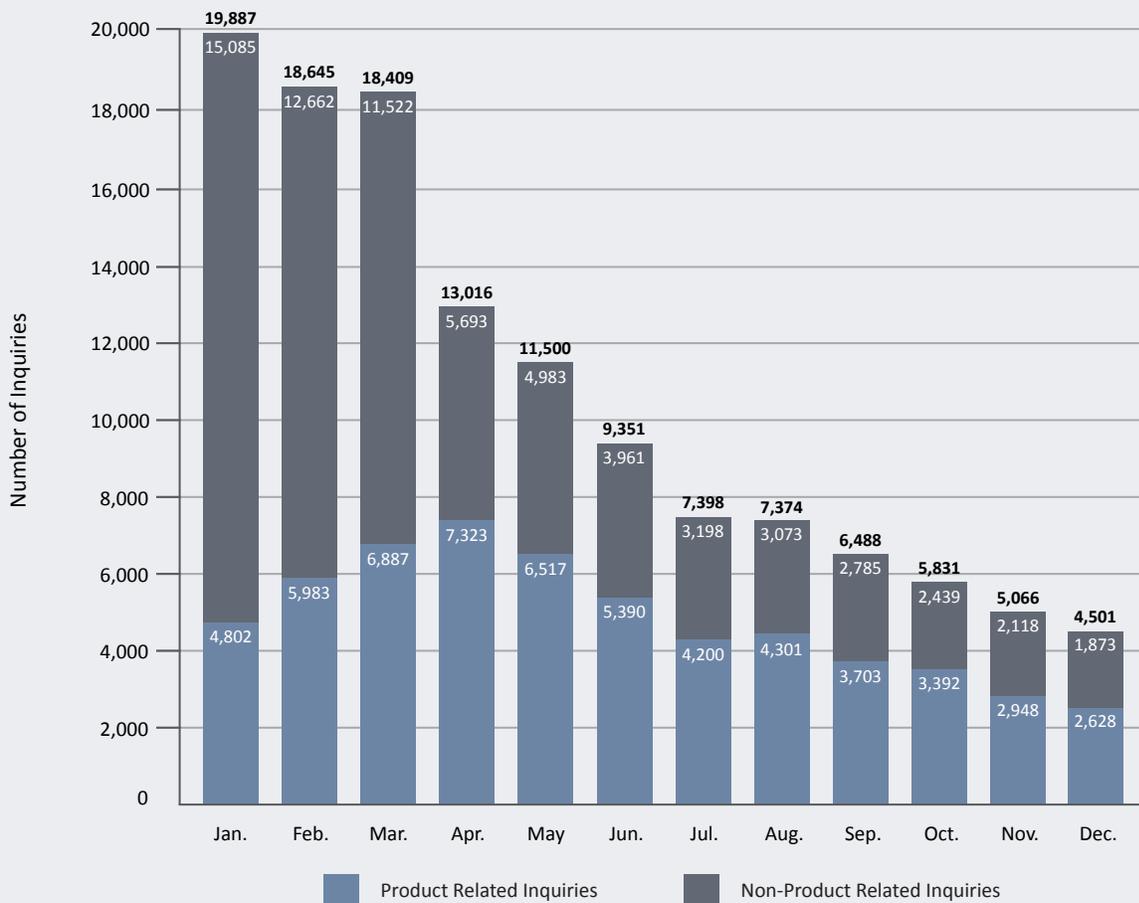
Please note that the charts that follow include data on inquiries, including those that were eventually escalated for resolution.

Monthly monitoring of inquiries made to 1-800-MEDICARE in 2011 was useful for identifying any potential systemic Program issues. Tracking these numbers was also important to the CAO's

**Figure 4. 2011 Competitive Bidding Program Inquiry Trends**

**Total Number of Inquiries**  
(01/01/2011 - 12/31/2011)

Total Number of Inquiries = 127,466  
Total Product Related Inquiries = 58,074  
Total Non-Product Related Inquiries = 69,392



Source: 1-800-MEDICARE



mission because each inquiry represented a Program stakeholder who needed DMEPOS information or equipment.

From January 1 to December 31, 2011, the 1-800-MEDICARE call center received 127,466 inquiries about the DMEPOS Competitive Bidding Program. Most beneficiaries who called had general questions about the Program or needed to find a supplier. These 'non-product inquiries' accounted for 54% of all Program contacts. The remaining

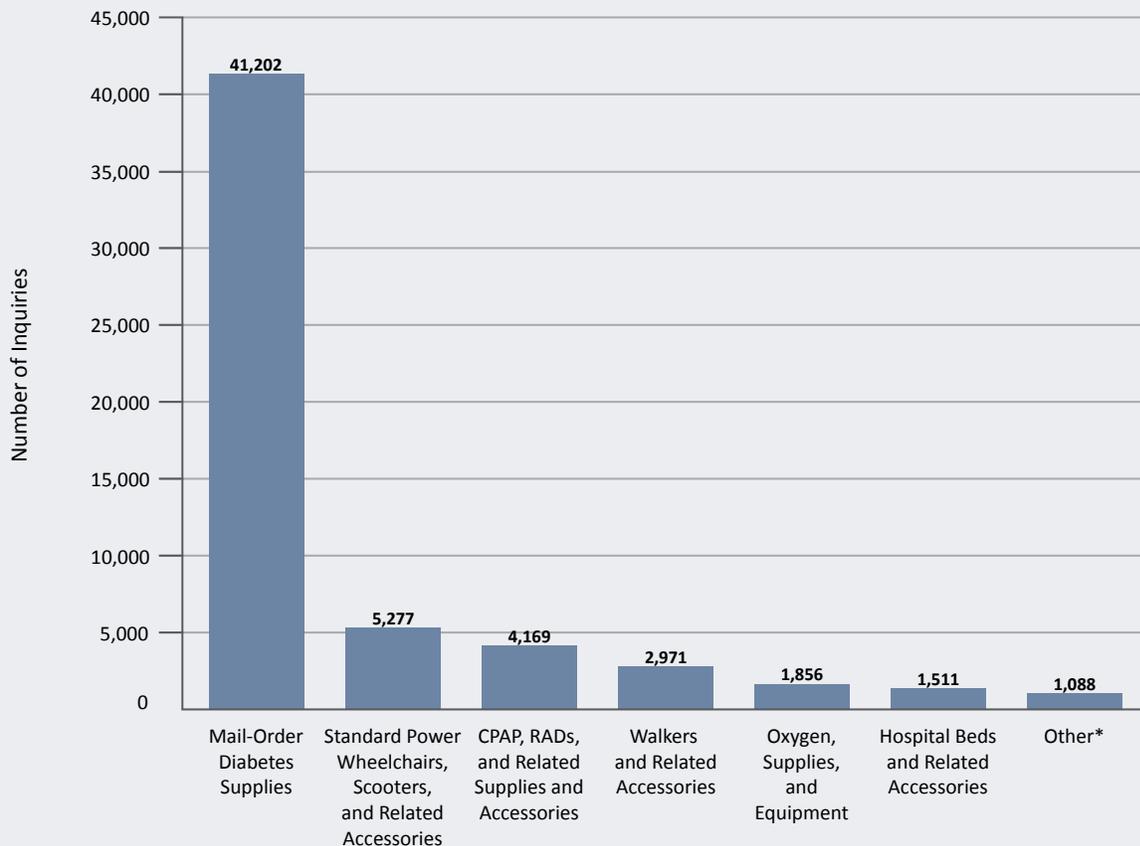
46% were 'product inquiries' regarding a specific DMEPOS item. During the year, total inquiries fell 77%, non-product inquiries fell 87%, and product inquiries fell 45% (see Figure 4).

Throughout the year, the majority of product inquiries were questions about diabetes testing supplies. This was not surprising because other Program products are either not refillable or need to be refilled less often than diabetes testing supplies. In addition, there is a large number of

**Figure 5. Number of Inquiries by Program Product Category in 2011**

**Number of Inquiries by Product Category**  
(01/01/2011 - 12/31/2011)

Total Number of Product Related Inquiries = 58,074  
45.6% Total DMEPOS CB Program Inquiries (127,466)



\*Other includes Complex Rehab Power Wheelchairs and Related Accessories, Enteral Nutrients, Equipment, and Supplies, and Support Surfaces (Group 2 Mattresses and Overlays, Miami CBA only)

Source: 1-800-MEDICARE



Medicare beneficiaries with diabetes. Several other factors also contributed to the higher number of calls from beneficiaries with diabetes. For example, some needed to find a new contract supplier because their previous supplier did not win a contract. Others wanted help finding a contract supplier that offered the particular brand of test strip that would fit their meters. Figure 5 shows the number of inquiries to 1-800-MEDICARE about specific Program products in 2011.

While most product inquiries (71%) were about mail-order diabetes supplies, it is important to note that these inquiries fell sharply by year's end (see Figure 6). In addition, 78% of these inquiries were from beneficiaries who needed to locate a new supplier.

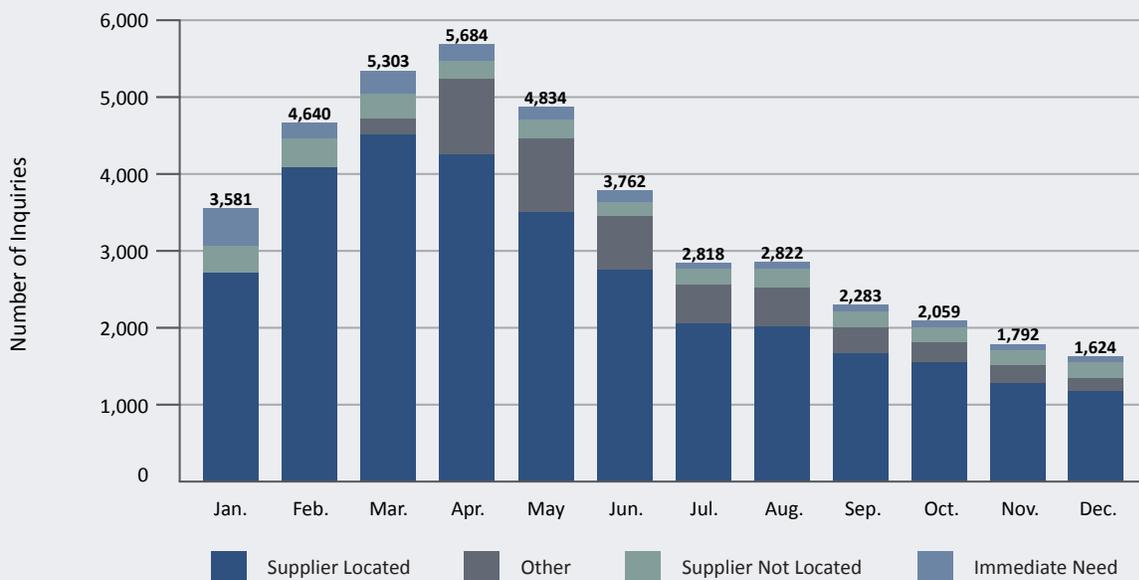
Because there were many inquiries about diabetes supplies, the CAO and staff at 1-800-MEDICARE broke them into sub-categories to better identify

any potential systemic issues (see Figure 6). These sub-categories were: *Diabetic Immediate Need*, *Diabetic Supplier Located*, *Diabetic Supplier Not Located*, and *Other*. Inquiries classified as *Diabetic Immediate Need* were from beneficiaries who were out of diabetes supplies and asked for help getting them quickly. Inquiries were classified as *Diabetic Supplier Located* when a Medicare customer service representative (CSR) successfully helped a beneficiary locate a contract supplier. When a CSR could not locate a contract supplier that offered the specific brand of test strip the beneficiary preferred and referred the beneficiary to a local pharmacy or storefront, the inquiry was classified as *Diabetic Supplier Not Located*. The title of this category should not be interpreted to mean that beneficiaries went without necessary supplies, only that they were referred to a retail outlet rather than a contract supplier to obtain the preferred brand of supplies. Inquiries classified as *Other* included questions about switching from specific suppliers and questions that

**Figure 6. Mail-Order Diabetes Supply Inquiry Trend in 2011**

**Mail-Order Diabetes Supplies Inquiries**  
(01/01/2011 - 12/31/2011)

Total Mail-Order Diabetes Supplies Inquiries = 41,202  
71.0% of Total Product Inquiries (58,074)



Source: 1-800-MEDICARE



needed further research. The latter were not classified as ‘complaints’ because the CSR followed up to respond without forwarding the inquiry to another CMS component.

Across all Program product groups, 4% of inquiries were defined as *Immediate Need* and most of these (79%) were about mail-order diabetes supplies. This means that the beneficiary had run out of supplies and could not travel to obtain them. Over the year, the total number of *Immediate Need* inquiries for mail-order diabetes testing supplies fell by 87%.

In 2011, the CBIC received 2,974 Program inquiries (see Figure 7). Eighty-five percent of these were from suppliers, 10% were beneficiary inquiries escalated from other CSCs, and 5% were from other stakeholders including CMS staff, referral agents, provider/supplier organizations, and consultants. Inquiries about policies and regulations accounted for 2,003 (67%) of the total, while 479 (16%) were

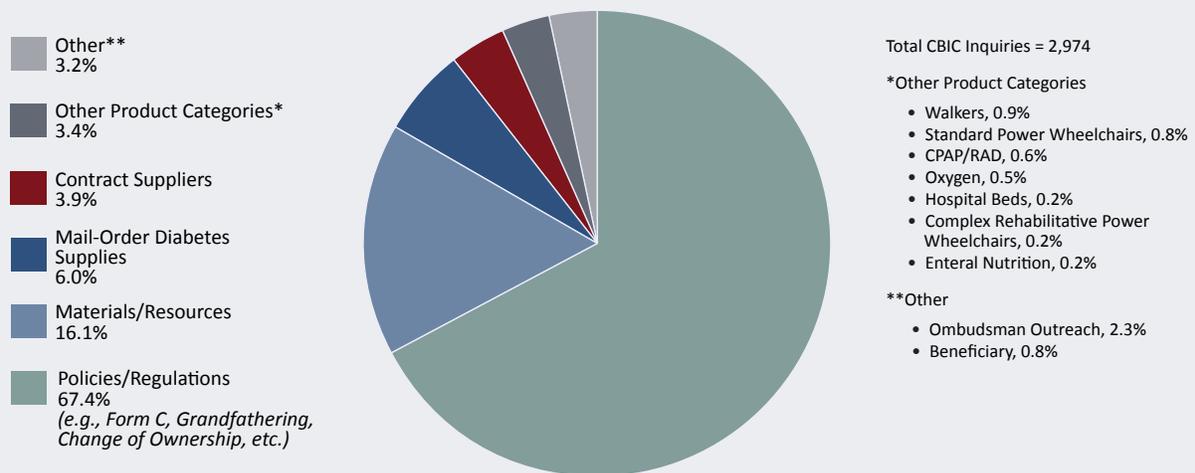
about materials and resources, and 179 (6%) were about mail-order diabetes supplies.

The DME MACs received inquiries from suppliers through their Provider Contact Centers. In 2011, suppliers contacted the DME MACs approximately 1.62 million times about DMEPOS. Less than 1% of these contacts (approximately 12,650) were about the Competitive Bidding Program. The great majority of inquiries regarded claim denials. Others were about policy, payment amounts, billing instructions, other complaints, and provider education. The ROs reported Program data for the entire year and received 235 inquiries related to it. Most of these were about Program/policy issues (35%), equipment access (34%), and issues with contracted suppliers (16%). Of all RO inquiries related to the Program, 78 came from Congressional offices, 76 from beneficiaries, 47 from providers, 11 from beneficiary representatives, 7 from advocacy groups, and 16 from other stakeholders.

**Figure 7. Annual Percentages of Total CBIC Program Inquiries by Category**

**Percentages of Total Inquiries by Category**

(01/01/2011 - 12/31/2011)



Note: 85.2% of CBIC inquiries were from suppliers, 9.7% were beneficiary inquiries escalated from other customer service components, and 5.1% were from other sources.

Source: Competitive Bidding Implementation Contractor (CBIC)



The CAO identified three priority areas for exploration in 2011 by tracking inquiry and complaint data and listening to stakeholder feedback at outreach events. Input from a small number of suppliers indicated questions about mail-order diabetes supplies, power wheelchairs, and CPAP devices. Because these products were more widely used than other DMEPOS Program items, there were relatively higher numbers of inquiries about them than others. Participants in the Partner Feedback Forum and Supplier Listening Sessions also confirmed that they had concerns about these products. Specific issues related to these products and the CAO's responses to them are discussed in the following section, *Response to Beneficiary and Supplier Issues*.



## RESPONSE TO BENEFICIARY AND SUPPLIER ISSUES

### Introduction

The CAO helped improve beneficiary and supplier experiences with the Program by responding to specific inquiries and complaints about it. The CAO used a six-step approach to identify and manage these concerns, and to raise Competitive Bidding Program issues for discussion within the Agency (see Table 2).

In the first step, the CAO monitored media reports, held Supplier Listening Sessions and a Partner Feedback Forum, and analyzed inquiry and complaint data to identify any emerging concerns about the application of the Program. Next, the CAO worked with other components to consider any substantial issues and determine their root causes—raising those that may be substantial to the appropriate CMS component. The CAO then worked within the Agency to facilitate a response that would

preserve beneficiary access to high quality products and services while protecting against fraud and abuse. Finally, the CAO helped communicate the Agency’s response and any related recommendations to outside stakeholders.

### Priority Issues in 2011

In 2011, the CAO identified inquiries and complaints about three types of products as its priorities for responsive action. There were more inquiries about these products than others, and specific issues related to them were discussed at length during the Partner Feedback Forum and Supplier Listening Sessions. These three products were:

- Mail-order diabetes supplies;
- Standard power wheelchairs; and
- CPAP devices.

Table 2. CAO Issue Management Steps

Step	Description
<b>1) Identify</b>	Identify issues through formal and informal mechanisms. Formal mechanisms include regularly scheduled events/meetings and identified data sources. Informal mechanisms include, but are not limited to, indirect or ad-hoc communications: the Internet, news, and conversations.
<b>2) Validate</b>	Identify the root cause of an issue and ask Subject Matter Experts (SMEs) to confirm it. Determine if the issue impacts many beneficiaries or suppliers or a substantial proportion of areas that are covered by the Competitive Bidding Program.
<b>3) Engage</b>	Involve appropriate parties early and often to work within and outside of CMS to address the issue until it is resolved. Maintain contact with these parties to build strong relationships for facilitating the resolution of future issues.
<b>4) Monitor</b>	Maintain information on the status of validated issues. Maintain engagement with SMEs to identify possible solutions.
<b>5) Resolve</b>	Facilitate issue resolution by bringing inquiries and potential solutions to the attention of Agency leadership or the responsible component.
<b>6) Communicate</b>	Communicate resolution strategies and Agency recommendations to stakeholders through appropriate mechanisms.



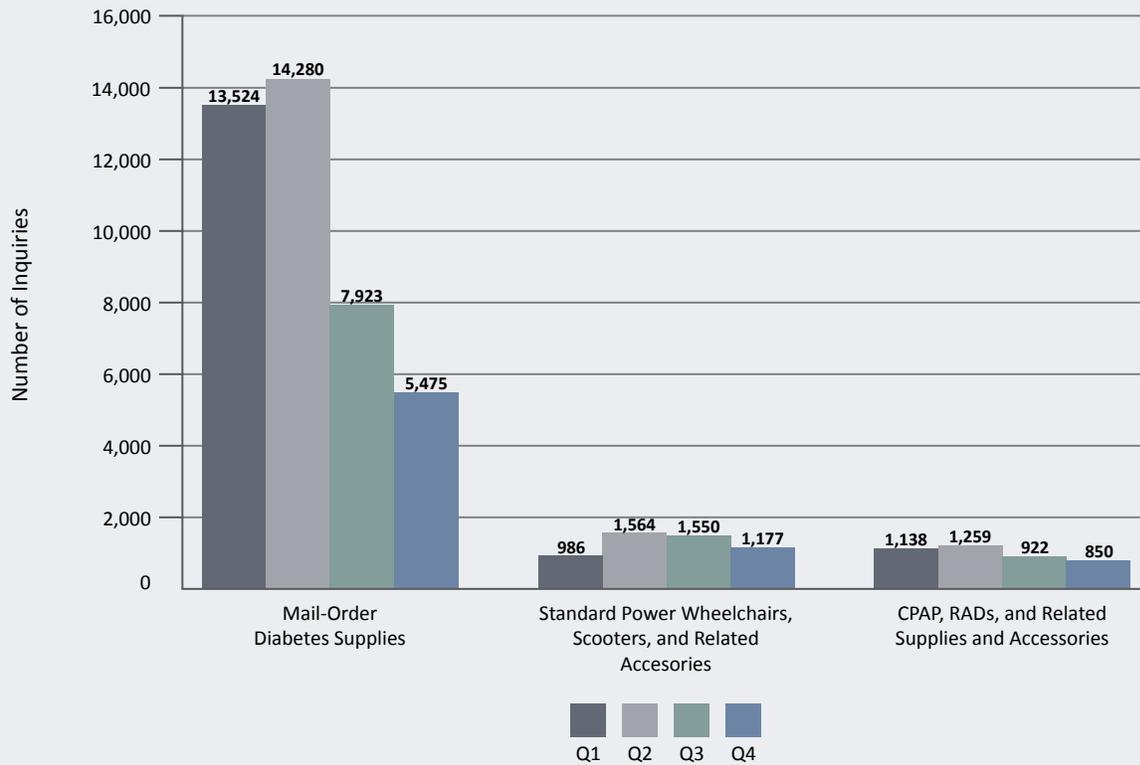
Figure 8 shows the quarterly number of inquiries received about each of these products in 2011. Call volumes illustrate that inquiries about these three

products peaked in the second quarter and declined in the third and fourth quarters as CMS responded to issues that were raised regarding them.

**Figure 8. Number of Inquiries in the Three Priority Product Categories in 2011**

**Number of Inquiries by Product Category**

(01/01/2011 - 12/31/2011)



Source: 1-800-MEDICARE



### Standard Power Wheelchair Repairs

The CAO identified power wheelchair repairs as an issue by listening to feedback from suppliers and beneficiary advocates, and analyzing 1-800-MEDICARE call center data. These sources indicated that some beneficiaries experienced difficulty locating suppliers and getting repairs for certain power wheelchairs (see Table 3). The CAO clarified the issue with suppliers and the appropriate CMS components and discussed possible resolutions with them.

Discussions with suppliers about wheelchair repairs and replacements brought up the need to clarify other, broader Medicare policies that are not unique to the Competitive Bidding Program. The need for suppliers to obtain medical necessity documentation is a Medicare policy that continues to apply unchanged under the Competitive Bidding Program. Some suppliers had difficulty obtaining the required medical necessity documentation they needed to bill Medicare for parts and/or repairs to wheelchairs they had not originally sold. When the CAO raised this issue, CMS issued a special notice to suppliers and providers confirming that referring physicians were responsible for providing required medical necessity documentation in these cases.

While investigating this issue, the need to clarify additional non-Program policies also arose. For example, the CAO learned that a supplier told

beneficiaries that they must bring their power wheelchairs to the supplier’s location for repair. The supplier stated that they believed Medicare reimbursement rates did not cover the cost of sending service personnel to beneficiaries’ homes to perform repairs. Upon consulting with CM, the CAO learned that the practice of asking beneficiaries to deliver their power wheelchairs to a supplier’s location for repair was not consistent with Medicare requirements and conveyed that information to suppliers.

The power wheelchair repairs issue clearly illustrates the value of the CAO’s issue management process. Elevated inquiries and conversations with suppliers alerted the CAO to potential issues with standard power wheelchair repairs. Eventually, several points about appropriate billing and repair practices for beneficiary-owned equipment emerged for clarification. While many of the issues raised were not about the Program, the CAO discussed each pertinent aspect with Agency leadership and described how it may be affecting beneficiaries in the Round One Rebid MSAs. CMS responded by clarifying its policies on wheelchair repair and developing new supplier education materials to clarify how provision, repair, and billing for standard power wheelchair equipment should be handled.

The following *Issue Spotlight* details how the CAO identified, explored, and responded to this issue.

**Table 3. 1-800-MEDICARE Inquiries About Standard Power Wheelchairs in 2011**

Standard Power Wheelchair Inquiry Subcategories	Q1	Q2	Q3	Q4
Equipment Repair	489	728	751	516
Supplier Located	348	628	599	499
Accessory Purchase	62	143	112	81
Supplier Not Located*	29	42	53	53
Immediate Need	58	23	35	28
<b>Total</b>	<b>986</b>	<b>1,564</b>	<b>1,550</b>	<b>1,177</b>

\*All inquiries in all subcategories were resolved. The category heading ‘Supplier Not Located’ should not be interpreted to mean that beneficiaries did not receive the DMEPOS items and services they needed.



## ISSUE SPOTLIGHT

### Power Wheelchair Repairs

In June 2011, the CAO held a Supplier Listening Session for DMEPOS suppliers and advocacy groups to talk about the Round One Rebid phase of the Competitive Bidding Program. During this meeting, suppliers raised several questions and concerns about Program policies related to providing power wheelchair repairs and also raised concerns about Medicare repair policies that apply broadly and are not specific to the Competitive Bidding Program.



The CAO explored their concerns within CMS and, in August, held a follow-up conference call to address them. During this call, representatives from a supplier who had problems providing power wheelchair repairs and CM staff discussed the issue in depth. The conversation clarified equipment repair policies under the Program and discussed non-Program issues, such as billing codes that are not compensable at the point of sale, suppliers' costs and abilities to provide repair services, and Medicare's labor and repair billing policies.

The CAO also conducted a focus group with CSRs from 1-800-MEDICARE to learn more about the wheelchair repair-related inquiries they were receiving. Through the process of discussing and validating the issue with stakeholders, it was noted that beneficiaries and suppliers did not fully understand the guidelines for power wheelchair repairs and replacements. The distinction is that repairs can be performed by any supplier and replacements can only be furnished by contract suppliers. Thus, some non-contract suppliers were reluctant to make certain repairs.

The CAO presented its findings to Agency leadership and, in September 2011, CMS held internal meetings with several components to review all of the feedback it had received on the issue. As a result, the Agency clarified the distinction between repairs and replacements. CMS responded in the short term by issuing a clarified policy statement to all Competitive Bidding Program suppliers. For the long term solution, CMS revised supplier education materials to clarify the distinction between a repair and item replacement.

In October 2011, the CAO attended a large, national supplier conference and exposition to report on this issue and explain power wheelchair repair policies under the Program. On December 9, 2011, CMS issued a revised Wheelchair Repair Fact Sheet clarifying wheelchair repair and replacement rules.

### CPAP Device Medical Necessity Documentation

Several contract suppliers told the CAO about problems they faced in obtaining all of the required medical necessity documentation for beneficiaries using CPAP devices. The CAO explored this issue in Supplier Listening Sessions, meetings, and calls with suppliers and beneficiary advocates, and then raised it to CMS' policy components as a potential concern. In keeping with the role of an ombudsman, the CAO

worked to explain the challenges beneficiaries and suppliers raised to CMS and to remind suppliers and beneficiaries about relevant documentation policies which are provided in the National and Local Coverage Determinations (NCD and LCDs).

At the heart of this issue was the fact that five documents are required for CPAP device and supply reimbursement. These documentation requirements apply to all CPAP suppliers (not just those under the Competitive Bidding Program) whenever a



beneficiary transitions to a new supplier. However, contract suppliers that accept new beneficiaries may be affected by this policy. The required records include:

- Initial Face-to-Face Exam — A face-to-face exam, prior to the sleep study, which documents symptoms of obstructive sleep apnea.
- Sleep Study — A laboratory sleep study or home sleep test to demonstrate a qualifying apnea-hypopnea index.
- Sleep Study Results Analysis — Interpretation of the sleep study results by a physician who is board certified in sleep medicine (or a physician with other qualifying criteria).
- Objective Evidence of Adherence — To document that the patient is using the CPAP device as prescribed. (This evidence is often documented by the previous supplier).
- Follow-up Face-to-Face Exam — A follow-up exam with a physician after the patient has been on therapy for at least 30 days to document that: 1) the apnea symptoms have improved, and 2) the physician reviewed the objective evidence of adherence.

During a meeting with suppliers, they told the CAO about several factors that they claimed contributed to their CPAP documentation concerns. For example, the five required documents were not stored together, and it was time-consuming and expensive to collect them from several places. Contract suppliers reported that the difficulty of collecting required documents was sometimes exacerbated by the fact that they could not get documentation from the original supplier. In addition, because the new, contract supplier did not have an existing relationship with the transitioning beneficiary, suppliers complained that they had to obtain a signed Health Information Portability and Accountability Act of 1996 (HIPAA) release form before any documents could be turned over.

The CAO continues to engage suppliers, beneficiary advocates, and internal Agency components in discussing CPAP medical necessity documentation requirements for transitioning beneficiaries. The CAO also continues to communicate regularly with

supplier and beneficiary stakeholders to update them as appropriate on CMS discussions about CPAP medical necessity documentation requirements. In all of these communications, the CAO emphasizes that the Agency's priority is to optimize beneficiary access while maintaining protections against fraud and abuse.

***The CAO continues to engage suppliers, beneficiary advocates, and internal Agency components in discussing CPAP medical necessity documentation requirements for transitioning beneficiaries.***

**Mail-Order Diabetes Supplies**

In 2010, the CAO's demographic study found that diabetes testing supplies were the most commonly used DMEPOS Program product in the nine Round One Rebid areas. Feedback from diabetes advocacy organizations and suppliers also indicated that this was a category of interest to many stakeholders. Thus, the Agency was prepared to address beneficiary calls about mail-order diabetes supplies that were received when the Program began (see *Competitive Bidding Program Inquiry and Complaint Trends*).

Because beneficiary advocates and suppliers expressed concern about this product category before the Program began, the CAO explored diabetes supply use, costs, and acquisition practices to learn more. This effort to proactively understand stakeholders' concerns found that some of the most important issues for beneficiaries with diabetes were pricing, availability of particular testing supplies at retail versus mail-order outlets, timeliness of testing supply delivery, costs of particular testing supplies at retail versus mail-order outlets, and supplier product offerings. This information helped the CAO prepare to respond to inquiries that might arise when the Program began.

The following *Issue Spotlight* describes how the mail-order diabetes supply issue first came to the CAO's attention in 2010 and CMS' response.



## ISSUE SPOTLIGHT

### Mail-Order Diabetes Supplies

In September 2010, the CAO held a conference call with representatives from the American Diabetes Association (ADA) to discuss their concerns and for the CAO to clarify Program policies for beneficiaries with diabetes. During this call, the CAO explained that beneficiaries would continue to have access to a wide variety of diabetes supply brands and be able to purchase them through retail or mail-order outlets after the Program began.



The CAO also learned that some beneficiaries received misinformation about the Program, including that it would limit them to low quality diabetes products and force them to switch from their preferred brand to another.

As a result of this conversation, the CAO worked within CMS to provide a fact sheet to CSRs at the ADA's call center to help them assist beneficiaries in obtaining diabetes supplies under the Program. The CAO also obtained a contact list of all ADA affiliates and worked with local chapters to disseminate accurate Program information to their members.

Despite these efforts, a high number of inquiries about diabetes supplies was noted after the Program began. The CAO discussed this with representatives from the 1-800-MEDICARE call center in one of their bi-weekly operational meetings during the first quarter of 2011. This discussion prompted the CAO to continue working to determine the root causes of these inquiries and to closely monitor the 'Diabetes Supplies' category in its Issues Management Report.

Discussions with 1-800-MEDICARE staff revealed that many calls were from beneficiaries who had previously purchased supplies from a large, national company that did not receive a contract under the Program. The dominance of this one supplier was the underlying cause for the high volume of calls from beneficiaries who needed to locate a new, contract supplier. To better track this phenomenon, 1-800-MEDICARE staff developed a separate category to capture calls from this company's previous customers.

Discussions with beneficiary advocates and suppliers also revealed that many 'Immediate Need' diabetes supply calls were from beneficiaries who waited until their supplies ran very low before ordering more. In response, the CAO worked with organizations in the diabetes community to encourage their members not to wait until they were out or nearly out of supplies before re-ordering.

### Other Issues in 2011

In addition to the three priority issues previously discussed, while acting within the scope of its statutory role, the CAO heard supplier concerns about the July deadline for submitting Form C Quarterly Reports during the Round One Rebid which the CAO then raised to CM. The Form C Quarterly Report collects information from contract suppliers about the products they furnish, including model numbers and manufacturers. Suppliers are required to submit Form C within 10 calendar days of the end of each quarter. The primary purpose of Form C is to allow suppliers an opportunity to tell beneficiaries which brands they plan to offer under

the Program. This information is posted on the Supplier Directory on [www.medicare.gov](http://www.medicare.gov) and allows beneficiaries with a brand preference to identify suppliers that offer the brands they wish to obtain.

In the Spring of 2011, suppliers told the CAO about challenges presented by the upcoming Form C deadline in early July. Suppliers reported that it was difficult to complete and that the submission date was too close to other supplier deadlines. Suppliers complained that Form C was burdensome because it was not electronic and asked for a great deal of information. Suppliers also questioned the value of gathering this information.



After hearing these issues, the CAO raised them to CMS leadership. In response to contract supplier concerns, CMS streamlined Form C reporting requirements starting with the October submission and began exploring the possibility of automating Form C submissions. In the meantime, the Agency has updated the online, printable version to conform to the newly revised reporting requirements and better accommodate data entry.

The CAO continues working with the supplier community to respond to inquiries and complaints concerning administrative requirements that can be made more user-friendly. Other internal Agency components that are responsible for these requirements also continue working diligently to streamline Program processes.



## LOOKING AHEAD

### CAO Objectives

Moving forward, the CAO will continue supporting CMS by responding to supplier and individual inquiries and complaints about the Program and supporting related Agency efforts for Round Two. To do this, the CAO will monitor and report inquiry and complaint trends, and provide a conduit for two-way communication between Agency components and beneficiaries and suppliers who are covered by the Program.

Over the next year, the Agency will increasingly focus on preparing for Round Two and the national mail-order Competition for diabetic testing supplies. This expansion will bring many more people and products into the Program, including high numbers of beneficiaries living in large, urban centers such as Houston, Chicago, New York, and Los Angeles. In light of this, the CAO will continue collaborating with CMS' Partner Relations Group, Office of Minority

Health, ROs, and the SHIPs to ensure that everyone, including vulnerable and hard-to-reach beneficiaries, has access to appropriate information about the DMEPOS Competitive Bidding Program.

The CAO's three main objectives as the program expands are to:

1. Communicate the CAO's role and how suppliers and individuals can get responses to Program inquiries and complaints.
2. Ensure that processes for responding to Program inquiries and complaints are defined, documented, and communicated.
3. Monitor and report Program inquiry and complaint trends to help CMS identify potential systemic issues and opportunities for improvements.

Table 4 describes how the CAO specifically aims to fulfill these objectives.

Table 4. CAO Specific Aims in Relation to its Main Objectives

Objective(s)	Specific Aim
1	Respond to 100% of CAO inquiries within 10 business days.
2	Facilitate customer service component trainings to close any knowledge gaps about the Program.
3	Share research reports within the Agency that can inform Program communication and outreach strategies.
1 and 2	Improve the CAO Web page by enhancing content.
3	Disseminate CAO Quarterly Reports more broadly to enhance Agency-wide awareness of Program trends and issues.
1, 2, and 3	Build relationships with beneficiary and supplier stakeholders in the Round Two MSAs.
1 and 2	Collaborate with other components on strategies to educate vulnerable and hard-to-reach beneficiaries about the Program.



## **Suggestions to Improve Supplier and Beneficiary Experiences**

At the end of 2011, one issue the CAO raised to Agency leadership remained partially unresolved—medical necessity documentation for CPAP devices. Although these documentation requirements apply to all suppliers and are not unique to the Competitive Bidding Program, the issue is of particular interest to contract suppliers who may see a surge of beneficiaries transitioning to them from non-contract suppliers when the Program begins in their areas. To address this issue the CAO engaged multiple CMS components in discussions regarding the need to ensure that documentation adequately supports medical necessity while continuing to address fraud and abuse concerns and balance the burden this places on suppliers to gather the necessary documentation. The CAO and many other CMS components continue working to find effective solutions that will fully address this issue.

In the meantime, the CAO suggests the following strategies:

1. Enhance communications with physicians, suppliers, and beneficiaries about CPAP medical necessity documentation; and
2. Ensure that educational materials contain recently updated and detailed information written in plain language.

