

Program Advisory and Oversight Committee (PAOC) for Quality Standards and Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Meeting Summary July 21, 2009

The Program Advisory and Oversight Committee (PAOC) met via teleconference on Tuesday, July 21, 2009, from 2 pm to 5 pm. PAOC members in attendance were: Tom Jeffers, Barbara Rogers, Kendra Betz, Richard Boulger, Rita Hostak, Joe Furlong, Ann Kohler, Jeff Mansell, Tom Milam, Peter Amico, Ruben King-Shaw, Esta Willman, Walt Gorski and Debra Zak; absent: Doran Edwards, Sharad Mansukani and Sue ElHessen.

The primary purpose of the meeting was to discuss and solicit feedback and suggestions on:

- determining beneficiary demand for items within the product categories,
- assessing bidding suppliers' ability to meet the demand (capacity), and
- reviewing regulations for change of ownership and the sale of contracts.

The meeting opened with remarks from Jon Blum, Director of the Center for Medicare Management (CMM) at the Centers for Medicare & Medicaid Services (CMS), who thanked the PAOC members for their contributions during the June 4th PAOC meeting and stated there was still work to be done. He again stressed the importance of the program achieving a balance between ensuring beneficiaries' access to items and services and having a competitive marketplace. He pointed out that the payment rule was released on July 13, 2009, and contained proposed rules on reviewing damage claims from the termination of the round one of competitive bidding damages and grandfathering under the competitive bidding program. He concluded his remarks by thanking the PAOC members for participating in the call and looked forward to their feedback and comments on suggestions outlined in the PowerPoint presentations provided prior to the meeting.

Tom Jeffers, Vice President of Government Affairs at Hill-Rom, Inc., and co-chair of the PAOC, thanked members for their participation in the call and encouraged them to share their ideas. He recognized and thanked CMS staff for soliciting ideas and formulating suggestions for this meeting. Laurence Wilson, Director, CMS Chronic Care Policy Group, CMM, noted the agenda topics and explained that the presentations would be made by CMS staff and followed by discussion. He would moderate the discussions. Members were welcome to ask questions throughout the presentations.

Systems Update

Rich Cuchna, Deputy Director, Provider Communications Group, CMM, stated that the registration system, referred to as IACS, has been tested and is ready to go. Testing has also been completed for DBidS, the on-line bidding system, and the system is now being fine tuned. Extensive DBidS testing has been conducted to insure that all business requirements have been met and that the system functions and performs as intended to include handling peak capacity, security requirements, and response time. Mr. Cuchna confirmed the system was in good shape. There were no questions or comments from the PAOC members.

Demand Determination

Chris Molling, Health Insurance Specialist, CMS Division of DMEPOS Payment Policy, reviewed the slides on how beneficiary demand for the items in a product category is determined and cited the federal

regulation that explains the process. The demand is calculated, using the final year of the contract, at the HCPCS level for the product category in the CBA. Historical utilization for each item is derived from the DMEPOS claims database.

PAOC Discussion

One PAOC member questioned the source of the data displayed on slide 5 and how the projected volume increase was determined. CMS explained that the data was from the 2007 Medicare Trustees Report for growth in beneficiary services and also includes expected fee-for-service growth in beneficiary enrollment based on historical trend data. CMS will follow up with the specifics on how the data displayed on the slide was determined. Another member questioned the basis of the enrollment data and CMS explained that it was based on historical trends using actual enrollment in the Medicare program not disease status. CMS also pointed out that CMS erred on behalf of beneficiary access and inflated the estimate for market demand, which would result in more contract suppliers.

Capacity Determination

Lorrie Ballantine, Acting Deputy Director, CMS Division of DMEPOS Payment Policy, reviewed the presentation on how suppliers' capacity to meet beneficiary demand is currently determined. CMS is using 2008 bid data to test and analyze various options to ensure the methodology results in a sufficient number of contract awards and achieves savings. Ms. Ballantine outlined capacity suggestions made at the June 4th PAOC meeting including: 1) provide for capacity that exceeds the projected demand, 2) reduce the estimated capacity of suppliers that are new to a product category or CBA, 3) do not include capacity of suppliers new to an area or product category, regardless of financial strength, 4) limit new suppliers' capacity that do not meet a high financial threshold, and 5) conduct extensive review of suppliers' expansion plans if estimated capacity exceeds actual utilization by a certain magnitude.

PAOC Discussion

A member expressed concern over suppliers' operational readiness to meet beneficiaries' needs when the program is implemented on "Day One." CMS again stressed that the demand estimate is generous to ensure there are enough suppliers awarded contracts to meet beneficiaries' needs. Another member asked if suppliers' stated capacity is compared to actual capacity. The member asked if the stated capacity was "wrong," what action would be taken during evaluation of the bids. CMS affirmed that the stated capacity is compared to past claims data and may be adjusted dependent upon the supplier's financial score. In accordance with regulations, capacity is generally capped at 20 percent of the overall expected demand to ensure a least five contracts are awarded in a CBA for a product category. One member stated that it was difficult to predict capacity and there is no future guaranteed capacity.

Several members agreed that the methodology appeared to be reasonable; however, from the experiences of round one it appeared that there were not enough suppliers to meet demand. Discussion ensued about causes or reasons for the possible disconnect. CMS explained that all locations must be licensed at the time of bid submission for the product category in the CBA. This is not a change from the first round; however, there were issues during the first round that complicated licensure verification. A member asked if a supplier had to have a physical location in the state to be licensed for that state and CMS replied that it was dependent upon the specific state's regulations.

CMS asked for input on financial thresholds that should apply to suppliers with no experience in providing the items in the product category. CMS reviewed the suggested methodology to assign a higher threshold to such suppliers. One member stated that all contract suppliers, not just "new" suppliers, should be held to a high financial standard in order to participate in the program and have their expanded estimated capacity counted. Several members expressed concern that the financial standards should not be the determinant as many small suppliers may not have strong financial scores yet provide exceptional

service. A member asked whether CMS reviewed and verified suppliers' extended credit limits. Another member concurred that suppliers may intend to expand to meet their projected capacity but have credit limit problems. CMS explained that suppliers when submitting a bid must indicate their credit status and submit documentation along with their required financial documents. These documents are reviewed during bid evaluation.

One member suggested that CMS offer contracts to a set percentage of all suppliers, such as 70 percent. This would ensure demand was met, create greater supplier participation in the bidding process, and prevent irrational bids. CMS asked for clarification on the 70 percent standard and expressed concern about offering contracts to a fixed number of suppliers. CMS also questioned what a supplier's incentive would be to provide the best possible bid if there was a "guaranteed" number of contract winners.

A member suggested that the single payment amount not be the median amount of the winning bids but rather the highest bid amount. Using this method, suppliers who bid lower would receive a higher reimbursement amount and would not be forced to accept an amount less than what they bid.

Change of Ownership (CHOW) and Sale of Contracts

Sabrina Teferi, Health Insurance Specialist, CMS Division of DMEPOS Payment Policy, reviewed the CHOW reporting requirements and how CMS intends to evaluate CHOWs in regards to the Competitive Bidding Program. Ms. Teferi stressed that regulations do not permit the sale of contracts but allow a contract supplier to enter into a CHOW transaction. However, CMS is concerned about suppliers submitting a bid with the intent of selling the contract. She asked for suggestions on how CMS can distinguish between a contract sale and a CHOW and how CMS should educate suppliers on this distinction.

PAOC Discussion

A member noted that suppliers are required to notify their accrediting organization within 30 days if there is a CHOW. Another member acknowledged that this may be an issue but CMS should deal with it on a case-by-case basis as it occurs. One member brought up a situation that occurred during round one where contract suppliers were contacted by non-contract suppliers who offered to pay the contract supplier an administrative fee for billing for items furnished by the non-contract supplier. Several members concurred that this situation had occurred and that they knew this was not in accordance with Medicare policy and not considered a legitimate subcontracting arrangement.

Other Agenda Topics

Mr. Wilson opened the meeting up for discussion on other issues.

New Suppliers: One member suggested that there be a general plan of care that suppliers new to the product category must submit to demonstrate that they understand and are capable of providing the items and services.

CBAs: Another member expressed concern that rural areas are included in some CBAs, which may create a hardship on beneficiaries when contract suppliers are unwilling to travel to serve those beneficiaries. CMS stated that MIPPA mandates that the same areas, as those included in the original round one. Furthermore, contract suppliers are required to serve any beneficiary who resides in or visits a CBA.

Financial Documents: A member suggested that CMS require suppliers to submit an IRS 4506T form with their financial documents, which would authorize the IRS to provide the tax extract for bid evaluation purposes. This would potentially eliminate attempts to submit fraudulent extracts. CMS will explore this suggestion further.

Subcontracting Rules: A member followed up on her question asked during the June 4th PAOC meeting as to whether a leased arrangement was in compliance with the subcontracting rules under the supplier standards. CMS said that they would follow up with the CMS Office of Financial Management, which is responsible for enrollment and the supplier standards. Another member commented there was much confusion about subcontracting rules and suggested that education be provided up front to assist suppliers. CMS stated that the Office of Financial Management was working on providing clearer direction on this issue and the rule outlined in MIPPA.

Diabetic Testing Supplies: One member expressed concern about contract suppliers offering lesser quality items or brands. The member asked if the process outlined in MIPPA would be applied to the rebid of round one. CMS stated the MIPPA requirements were for round two, not the rebid. However, CMS intends to monitor the situation closely and provide guidance for suppliers and beneficiaries.

Accreditation: A member pointed out that the House version of the health care reform bill contained a provision that suppliers may have pending accreditation at the time of the deadline, September 30, 2009. The member asked how this would impact the competitive bidding rule that all locations be accredited. CMS responded that the existing rule would continue to apply unless Congress passed a law before the accreditation deadline that changed the rules.

Timeline: A member asked when the timeline for opening of registration and bidding would be released and CMS said they expected a detailed timeline that is consistent with the general timeline will be announced very soon.

Transcripts of Meetings: A member also asked if minutes or a transcript of the June 4th meeting was available. CMS responded that a summary will be posted on the CMS website of the June 4th meeting and of this meeting.

HCPCS Codes: A member acknowledged that there may be a wide variety of products within a single HCPCS and understood that CMS was working on this coding issue. CMS affirmed that the same HCPCS codes that were used in the original round one would be included in the rebid as mandated by MIPPA. CMS encouraged the members to provide advice on this issue. CMS also explained the scenarios of what would occur if a HCPCS code was added, deleted or merged with another code following implementation. The scenarios are outlined in the final rule.

There being no further issues for discussion, Mr. Blum thanked the PAOC members for their participation and good discussion of agenda topics. Mr. Blum also asked the PAOC for feedback on the telephone format and requested that members submit agenda topics for future meetings. A summary of this meeting will be provided to members and posted on the CMS website.