

**From Insight to Impact**  
– worldwide

**Baseline Case  
Study Report**

**Evaluation of the  
National DMEPOS  
Competitive  
Bidding Program**

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# Executive Summary

Pursuant to Section 302 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (Pub. L. 108-173), in 2008 the Centers for Medicare & Medicaid Services (CMS) began to phase in a competitive bidding program for durable medical equipment (DME), enteral nutrition, and off-the-shelf orthotics as a permanent part of Medicare. CMS contracted with Abt Associates, Inc., (Abt) to evaluate Round One of the competitive bidding program. The evaluation uses a difference-in-differences, quasi-experimental design wherein Competitive Bidding Areas CBAs will be compared with non-CBAs before and after the implementation of Durable Medical Equipment, Prosthetics, Orthotics and Supplies DMEPOS competitive bidding. In 2007, baseline case studies and beneficiary surveys were conducted in CBAs and comparison areas. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referred to as the Round One Rebid. The baseline case studies were repeated in 2010 and are described in this report.

## Case Study Methodology

Qualitative data collection was conducted in four of the first nine CBAs, and three comparison areas, and consisted of focus groups and key informant interviews. The Dallas, Orlando, Riverside, CA and Cleveland CBAs were selected for case studies, as well as Houston, Tampa and San Diego as comparison areas. Participants included suppliers, knowledgeable industry and advocacy representatives, and referral agents (individuals actively involved in connecting Medicare beneficiaries to DMEPOS suppliers and/or products, for example home health nurses and hospital discharge planners). Focus groups were conducted with suppliers and referral agents to provide grassroots-level understanding of the environment prior to implementation of the competitively-bid contracts; key informant interviews supplemented these views with broader context.

## Baseline Cross-Site Themes

### Current Market Capacity, Adequacy and Competition

Referral agents, suppliers and key stakeholders in each market share the view that the current number of DMEPOS suppliers in CBAs and comparison areas is sufficient to meet most existing needs of Medicare beneficiaries. For products prescribed most often (e.g., wheelchairs, walkers, oxygen) the number of suppliers appears to be more than adequate in all sites.

Case study participants, including suppliers, believe that intense competition has had a very positive effect on service access and quality. The four CBAs and three comparison site areas each have substantial DMEPOS capacity, and suppliers compete on timely equipment delivery, product quality, patient education, skilled technical and clinical staff (e.g., respiratory and physical therapists), after-hours delivery and maintenance, and responsiveness to complaints.

Referral agents are able to choose among many large and small suppliers, and they maintain lists of those they prefer. They favor suppliers that provide generally outstanding service, and that accept all payers so that there is less concern with matching the patient with an authorized supplier. Many referral agents expressed a preference for suppliers that can meet all of a patient's needs, eliminating the need to coordinate multiple suppliers for a single patient and reducing confusion for patients.

Hospital discharge planners value the ability to have a piece of equipment delivered to the hospital before a patient is discharged home, or immediately thereafter, without an interruption in service.

Suppliers have traditionally been referral agents' main source of information about the competitive bidding program and other DMEPOS matters. Suppliers regularly visit referral agents to provide updates on new equipment, and some conduct brief seminars that may provide continuing education credits for referral agents and other staff.

### **Anticipated Effects of Medicare Competitive Bidding**

Referral agents, suppliers, and elder service organizations voiced many strong concerns about the potential impact of Medicare competitive bidding for DMEPOS. They worry that the program will lead to a significant decrease in the number of suppliers available to serve Medicare beneficiaries and will reduce competition within the industry. All participants predict that current standards for timeliness, quality, and other service features will deteriorate when competitive bidding is implemented. They predict that response times will be slower, there will be fewer choices of products, and product quality will diminish as less expensive products replace those currently in use.

### **Role of Referral Agents**

Referral agents believe the referral process will become more complicated and time consuming under competitive bidding. They expect to be working with multiple suppliers to meet some patients' needs, and expect to shoulder more responsibility for dealing with patient problems and needs if services such as patient education are no longer provided by suppliers.

### **Winners and Losers (Suppliers)**

Many DMEPOS suppliers are convinced that they will not be able to sustain current levels of service at the prices they bid. They predict that the supplier market will change dramatically, with fewer suppliers available to serve beneficiaries' needs, because many small, local companies -- including independent, family-owned businesses -- will be forced to close or will be subsumed by larger companies.

Suppliers reported that they had no choice but to bid, and bid low, because they are dependent on Medicare. They found it hard to estimate operating costs and staffing needs in their bids, or estimate profits, because they were unable to anticipate volume. Larger companies, especially those affiliated with chains, can take advantage of bulk purchasing, centralized billing and distribution, shared resources, and other economies of scale that increase their chances of winning a contract and succeeding at the contracted price.

### **Program Awareness and Knowledge**

Suppliers have followed developments in the Medicare competitive bidding program, and their trade organizations have closely monitored the details and have attempted to keep their members well informed. Nonetheless, focus groups revealed that many suppliers do not fully understand the methods by which Medicare will weigh price against capacity, quality, and other criteria in evaluating bids. Referral agents appear to be much more aware of competitive bidding than were their counterparts in 2007. Beneficiary organizations, especially State Health Insurance Programs (SHIPs),

generally appear to understand the program features that are most relevant and important for their constituents to know.

Focus groups and interviews provided insights into gaps in knowledge about the program, and areas of misunderstanding that have persisted since 2007:

- Referral agents are not sure when and how they will learn which suppliers have been awarded Medicare contracts for particular products. As in 2007, they claim that they have received little communication from CMS.
- Very few suppliers or referral agents seem to be aware of the special provisions for suppliers in rural and low-density geographic areas; and while a few mentioned the program provisions that encourage participation of small suppliers, many voiced concern about the ability of small suppliers to compete effectively.
- Referral agents and suppliers have not focused on the fact that beneficiaries' out-of-pocket costs could be reduced by the competitive bidding program.
- A fundamental misunderstanding of the origins of, and responsibility for, the DMEPOS competitive bidding program persists. Many study participants (incorrectly) assume that CMS initiated and is responsible for all aspects of program design.

NOTE: The views expressed by participants (suppliers, referral agents, advocates and others) reflect opinions who provided during focus groups and interviews conducted by evaluators. These participant views do not necessarily reflect the rules and regulations of the Medicare DMEPOS competitive bidding program, or the opinions of the evaluators.

# 1. Introduction

Pursuant to Section 302 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (Pub. L. 108-173), in 2008 the Centers for Medicare & Medicaid Services (CMS) began to phase in a competitive bidding program for durable medical equipment (DME), enteral nutrition, and off-the-shelf orthotics as a permanent part of Medicare. The program was established after the conclusion of successful demonstration projects.

Nine product categories were identified as subject to Medicare competitive bidding:

1. Oxygen supplies and equipment;
2. Standard power wheelchairs, scooters, and related accessories;
3. Complex rehabilitative power wheelchairs and related accessories (Group 2 only);
4. Mail-order diabetic supplies;
5. Enteral nutrients, equipment, and supplies;
6. Continuous Positive Airway Pressure (CPAP) machines, Respiratory Assist Devices (RADs), and related supplies and accessories;
7. Hospital beds and related accessories;
8. Walkers and related accessories; and
9. Support surfaces (Group 2 mattresses and overlays in Miami only).

(The MMA included a tenth product category, negative pressure wound therapy [NPWT], that was eliminated from competitive bidding in subsequent legislation.)

Under the MMA, Competitive Bidding Programs for Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) were to be phased into Medicare so that competition under the program would occur in 10 areas in 2007. Consistent with the statutory mandate, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referred to as the Round One Rebid. The Round One 60-day “rebid” began on October 21, 2009, and the new competitive bidding rates will go into effect in nine CBAs on January 1, 2011. The program will lower Medicare payments as well as beneficiary out-of-pocket expenses for the nine categories of medical equipment and supplies.

CMS contracted with Abt Associates, Inc. (Abt) to evaluate Round One of the competitive bidding program. The evaluation uses a difference-in-differences, quasi-experimental design wherein Competitive Bidding Areas CBAs will be compared with non-CBAs before and after the implementation of DMEPOS competitive bidding. The evaluation will include analysis of DMEPOS claims from all nine CBAs and 18 comparison areas.<sup>1</sup> In 2007, to understand perceptions of the DMEPOS markets before the implementation of Medicare competitive bidding, Abt conducted baseline surveys of Medicare beneficiaries who use DME products and services, and qualitative case studies in Orlando, Dallas, and Cleveland (CBAs) and Tampa and Houston (comparison areas). Dallas, Orlando, and Cleveland were selected for the baseline because they have many suppliers that furnish the DMEPOS products included in the first round of competitive bidding, they have many

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<sup>1</sup> The same locations were used for baseline surveys of suppliers and beneficiaries. There is no study comparison area for Cleveland.

beneficiaries using these products, and two of the three have well-suited comparison areas in the same state. Baseline data were collected before Congress acted to amend and delay the program. These data reflected the DMEPOS markets in the selected communities in 2007 in terms of how referral agents (e.g., discharge planners, home health nurses, and case managers) chose DMEPOS suppliers for their patients, and how these suppliers competed with one another to meet their customers' needs.

In 2007-2008, other programmatic changes were enacted, including a requirement that all Medicare DMEPOS suppliers become accredited, and a 10% across-the-board reduction in the Medicare fee schedule for DMEPOS. These two changes altered the industry, reducing the number of Medicare suppliers nationwide. The changes may have had other effects, in terms of the products and services DMEPOS suppliers furnished to Medicare beneficiaries. For these reasons, the 2007 baseline data likely no longer reflect the state of the competitive bid Round 1 markets immediately before the rebid in 2010. Abt therefore collected another set of baseline data in mid-2010, to describe the current markets in the first CBAs and measure beneficiary satisfaction and experiences with their DMEPOS suppliers. Orlando, Dallas, Cleveland, and Riverside, CA, were studied, as well as Tampa, Houston, and San Diego, the latter three for comparison.

The objectives of the baseline case studies conducted in 2007, and repeated in 2010, included description of: 1) the baseline features of the environment in which DMEPOS are provided to Medicare beneficiaries; and 2) the knowledge and expectations of market participants regarding the introduction of competitive bidding. In each of the four CBAs studied, project staff conducted a focus group with DMEPOS suppliers and a focus group with "referral agents"—professionals who connect patients with DMEPOS suppliers. Interviews were also conducted in the four CBAs with knowledgeable DMEPOS industry representatives, beneficiary advocates, and healthcare organizations. Telephone interviews were also conducted with representatives of the DME industry and healthcare providers in the three comparison areas. This report synthesizes the views of referral agents, suppliers, industry organizations, and advocacy organizations in 2010, and documents changes in perceptions and opinions between 2007 and 2010. This report is organized in the following sections:

- Methodology and case study participants
- Current referral process and environment for DMEPOS and Medicare beneficiaries
- Functioning of the current market for DMEPOS, including quality of and access to DMEPOS and related services
- Market participants' expectations regarding the impact of competitive bidding on referral processes and the functioning of the DMEPOS market
- Findings from comparison areas
- Summary of cross-site themes

Approximately one year after reimbursement based on competitive bidding begins in 2012, follow-up surveys and case studies will be conducted, as well as a program cost analysis. All the analyses will compare intervention and comparison sites, before and after the program is implemented. The complete results of the evaluation will be contained in a final report to CMS, which will be posted to the CMS website. Provisional information from the evaluation project will be released in the Report to Congress (RTC) mandated in MMA 2003 and MIPPA 2008. The RTC will be written just before the program goes into effect in January 2011 and will be released in July 2011.

## 2. Case Study Methodology

Qualitative data collection consisted of focus groups and key informant interviews. The focus group and interview participants were selected to address related, but different, study objectives. Referral agents—individuals actively involved in connecting Medicare beneficiaries to DMEPOS suppliers and/or products—were asked about access to suppliers and to specific products. Complementary information regarding diversity/quality of products and quality of service was sought from DMEPOS suppliers (vendors who sell DMEPOS directly to Medicare beneficiaries). In addition, suppliers were asked about the nature of the CBA markets in which they do business. Key informants were interviewed about the anticipated effect of the program on persons within their professional domains. Key informant discussions were designed to give a higher-level view of the DMEPOS markets at baseline and the anticipated impact of the DMEPOS Competitive Bidding program. Focus groups were conducted to provide grassroots-level understanding of access to DMEPOS products and their quality in each community

Similar data collection activities were completed in 2007, before Congress amended and delayed the competitive bidding program. Comparisons between the findings of the 2007 and 2010 reports will be discussed further throughout this report.

### 2.1. Focus Groups: Referral Agents

We searched the Internet to identify institutions where referral agents might be found, such as hospitals, rehabilitation facilities, specialty clinics, and home health agencies. Potential focus group participants included directors of discharge planning, case management, social work, and physical therapy. We sought referral agents who understood their institution’s referral process for DMEPOS for Medicare beneficiaries, and who were familiar with the DMEPOS market in their community and the quality of DMEPOS goods and services currently available. Table 1 shows the numbers of referral agent focus group participants, by CBA and type of institution.

**Table 1 Focus Group Participants—Referral Agents**

	Dallas			Orlando			Cleveland			Riverside		
	Contacted	Agreed <sup>i</sup>	Participated <sup>ii</sup>									
Hospitals	9	4	3	6	4	4	7	4	4	6	2	2
Rehab Facilities	2	2	3	7	4	2	2	0	0	13	1	1
Specialty Clinics	12	1	1	12	1	1	2	0	0	2	0	0
Home Health Agencies	16	6	3	3	0	0	2	3	3	12	4	4
<b>TOTAL</b>	<b>39</b>	<b>13</b>	<b>10</b>	<b>28</b>	<b>9</b>	<b>7</b>	<b>13</b>	<b>7</b>	<b>5</b>	<b>33</b>	<b>7</b>	<b>7</b>

<sup>i</sup> We aimed to recruit 10-12 focus group participants with the expectation that some would not attend.

<sup>ii</sup> Some of those who agreed to participate did not attend, despite repeated reminders. The “no show” rate was lowest in Riverside.

We initially contacted participants from the 2007 case studies, and asked if they would participate in another focus group or interview. Potential participants were contacted via telephone, email, and occasionally through fax correspondence.

Case study participants are not representative of the entire supplier or referral agent populations, but rather constitute a convenience sample of individuals who agreed to participate. Many individuals refused to participate for reasons including time constraints, lack of upper management approval, and concerns about confidentiality. Focus group participants received a \$75 honorarium for their time. Table 2 below lists each participant's title, type of organization represented, the types of clients that their organization serves, and the specific role of the participant relative to securing DME services.

**Table 2 Referral Agent Focus Group Participants**

<b>Participant Title</b>	<b>Type of Organization Represented</b>	<b>Role vis-à-vis DMEPOS</b>
<i>Dallas (10)</i>		
Social Worker	Hospital	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Social Worker	Hospital	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Social Worker	Hospital	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Social Worker	Specialty Clinic	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Office Manager	Home Health Agency	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Office Manager	Home Health Agency	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Social Worker	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Case Manager	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Director of Patient Care Services	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
Director	Home Health Agency	<ul style="list-style-type: none"> <li>• Orders DME1</li> </ul>
<i>Orlando (7)</i>		
Risk Manager	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Helps director with discharge planning, coordinates discharge and orders DME</li> <li>• Primarily helps patients recovering from knee or hip replacement, or a surgery where they need therapy</li> </ul>
Discharge Planner	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Orders DME</li> </ul>
RN in discharge planning	Hospital	<ul style="list-style-type: none"> <li>• Interviews patients to ask which DME they might want to use, connects them with necessary services</li> </ul>
RN, Referral Coordinator	Home Health Agency within a Hospital System	<ul style="list-style-type: none"> <li>• Establishes home care if needed</li> <li>• Works as after-hours nurse</li> <li>• Coordinates transfer from hospital to nursing home</li> </ul>
Social worker/discharge planner for rehab	Hospital	<ul style="list-style-type: none"> <li>• Helps patients recovering from brain injury or stroke receive the DME that they need</li> </ul>

<b>Participant Title</b>	<b>Type of Organization Represented</b>	<b>Role vis-à-vis DMEPOS</b>
unit		
RN, Case Manager	Hospital	<ul style="list-style-type: none"> <li>Refers all patients to the appropriate DME companies</li> <li>Interacts with a lot of HMOs and HMO physicians to order DME</li> </ul>
Referral Coordinator	Specialty Clinic	<ul style="list-style-type: none"> <li>Refers patients who need CPAP or oxygen to DME</li> </ul>
<b><i>Cleveland (5)</i></b>		
PT Assistant	Hospital	<ul style="list-style-type: none"> <li>Orders DME equipment for discharge to home</li> </ul>
Outpatient Pulmonary Rehab Coordinator	Hospital	<ul style="list-style-type: none"> <li>Does outpatient education</li> <li>Makes referrals for oxygen equipment and services</li> </ul>
Nurse	Home Health Agency	<ul style="list-style-type: none"> <li>Arranges for products and services to meet needs of for Medicare, Medicaid, and HMO home care patients</li> </ul>
Director of Nursing	Home Health Agency	<ul style="list-style-type: none"> <li>Deals with any complaints or issues</li> <li>Does not refer directly for DME equipment</li> </ul>
Social Management Manager	Hospital	<ul style="list-style-type: none"> <li>Works with suppliers, staff makes referrals for equipment</li> </ul>
<b><i>Riverside (7)</i></b>		
Clinical Nurse Manager	Home Health Agency	<ul style="list-style-type: none"> <li>Orders DME as needed: support services, oxygen, handheld nebulizers, wheelchairs</li> <li>Selects DME vendors based on the patient population or their response time</li> </ul>
Director of Case Management	Hospital	<ul style="list-style-type: none"> <li>Supervises case managers and social workers</li> </ul>
Director of Social Services	Nursing Home/Rehabilitation Facility	<ul style="list-style-type: none"> <li>Does discharge planning, and orders DME for home use</li> </ul>
Social Work Case Management Supervisor	Hospital	<ul style="list-style-type: none"> <li>Ordered DME in the past, but now supervises staff ordering the DME equipment</li> </ul>
Chief Nursing Officer	Home Health Agency	<ul style="list-style-type: none"> <li>When DME is broken or delivered late, tracks that with insurance and reports to State surveyors</li> <li>Helps patients with late equipment</li> </ul>
Director of Home Health and Hospice	Home Health Agency	<ul style="list-style-type: none"> <li>Orders DME</li> </ul>
Nurse Manager	Home Health Agency	<ul style="list-style-type: none"> <li>Does patient intake staff assignments</li> <li>Takes complaints/phone calls</li> </ul>

## 2.2. Focus Group: Suppliers

Using DMEPOS claims, we created a list of DMEPOS suppliers in each CBA and selected a mix of large and small suppliers, including independent suppliers and those affiliated with chains. Suppliers were contacted regardless of the DMEPOS products that they carry. We initially contacted participants from the 2007 focus groups and invited them to participate again. This set was augmented with suppliers who had not previously been involved. The owner, president, CEO, or regional manager of each organization was contacted, as this person was likely to be the most knowledgeable about the Competitive Bidding program, its associated processes, DMEPOS procurement, and sales to beneficiaries. In some cases, the owner or manager recommended other personnel to participate. Many refused to participate for reasons including time constraints and lack of corporate approval. Focus groups were conducted in June and July 2010, just as the suppliers learned whether their bid prices fell within the competitive range for Medicare contracting, which may have affected willingness to participate in the evaluation focus groups. When contacted, some suppliers reported that they had not submitted a bid or were going out of business, and therefore declined to attend the focus groups. Table 3 shows the number of supplier focus group participants by CBA.

**Table 3 Focus Group Participants—Suppliers**

	Dallas			Orlando			Cleveland			Riverside		
	Contacted	Agreed <sup>i</sup>	Participated <sup>ii</sup>									
<b>TOTAL</b>	<b>26</b>	<b>13</b>	<b>11</b>	<b>34</b>	<b>11</b>	<b>5</b>	<b>22</b>	<b>7</b>	<b>6</b>	<b>39</b>	<b>9</b>	<b>6</b>
<sup>i.</sup> We aimed to recruit 10-12 focus group participants with the expectation that some would not attend. <sup>ii.</sup> Some of those who agreed to participate did not attend, despite repeated reminders.												

Participants in the supplier focus groups received a \$75 honorarium for their time. The table below lists each participant’s title, the percentage of their clients who receive Medicare, the geographic area that they serve, and the type(s) of DME equipment that the company provides.

**Table 4 Supplier Focus Group Participants**

<i>Participant Title</i>	<i>Percentage of Clients that have Medicare</i>	<i>Geographic Area Served</i>	<i>Types of DMEPOS Provided</i>
<i>Dallas (11)</i>			
District Manager	No population information collected at Dallas <sup>i</sup>	National chain	<ul style="list-style-type: none"> <li>• Electroencephalogram (EEG)</li> <li>• Continuous Positive Airway Pressure (CPAP) / Bilevel Positive Airway Pressure (BIPAP)</li> <li>• Other DME</li> </ul>
Owner	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• CPAP</li> <li>• Oxygen</li> <li>• Nebulizers</li> </ul>
Office Manager	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• CPAP</li> <li>• Oxygen</li> <li>• Nebulizers</li> </ul>
District Manager	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• BIPAP</li> <li>• Oxygen</li> <li>• Enteral nutrition</li> </ul>
District Manager	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• BIPAP</li> <li>• Oxygen</li> <li>• Enteral nutrition</li> </ul>
Office Manager	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• CPAP</li> <li>• Oxygen therapy</li> <li>• Nebulizers</li> </ul>
President	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• Sleep therapy</li> <li>• Oxygen therapy</li> <li>• Nebulizers</li> </ul>
Owner	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• Full line of DME</li> </ul>
CEO	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• Oxygen</li> <li>• Nebulizers</li> <li>• CPAP</li> <li>• Beds, walkers, and commodes</li> </ul>
Owner	No population information collected at Dallas <sup>i</sup>	Local	<ul style="list-style-type: none"> <li>• Oxygen</li> <li>• Nebulizers</li> <li>• CPAP</li> <li>• Beds, walkers, and commodes</li> </ul>
General Manager	No population information collected at Dallas <sup>i</sup>	Regional	<ul style="list-style-type: none"> <li>• Oxygen therapy</li> <li>• Full line of basic DME</li> </ul>

<i>Participant Title</i>	<i>Percentage of Clients that have Medicare</i>	<i>Geographic Area Served</i>	<i>Types of DMEPOS Provided</i>
<b>Orlando (5)</b>			
Owner	80%	Local	<ul style="list-style-type: none"> <li>• Oxygen</li> <li>• CPAP</li> <li>• Hospital beds</li> <li>• Canes</li> </ul>
CEO	70%	Local	<ul style="list-style-type: none"> <li>• Oxygen</li> <li>• CPAP</li> <li>• Hospital beds</li> <li>• Wheelchairs</li> </ul>
President	35%	Local	<ul style="list-style-type: none"> <li>• Full line of DME</li> <li>• Custom rehab and home modifications</li> </ul>
President	10-15%	Local	<ul style="list-style-type: none"> <li>• Full line of basic DME</li> </ul>
President	85%	Local	<ul style="list-style-type: none"> <li>• Oxygen</li> <li>• CPAP</li> <li>• Enteral feeding</li> <li>• Beds</li> <li>• Wheelchair</li> <li>• Walkers</li> <li>• All DME except power wheelchairs</li> </ul>
<b>Cleveland (6)</b>			
Vice President of Sales	More than 50% Medicare	Local	<ul style="list-style-type: none"> <li>• Full line of basic DME</li> </ul>
President	Less than 50%	Local	<ul style="list-style-type: none"> <li>• Full line of basic DME</li> <li>• Oxygen</li> <li>• CPAP</li> </ul>
Vice President	Less than 50%	Local	<ul style="list-style-type: none"> <li>• Full line of basic DME</li> <li>• Oxygen</li> <li>• CPAP</li> </ul>
Owner	More than 50%	Local	<ul style="list-style-type: none"> <li>• Full line of DME: Oxygen, hospital beds, wheelchairs, and bathroom safety equipment</li> </ul>
DME manager	0% Medicare right now because of accreditation process, usually has more Medicare	Local	<ul style="list-style-type: none"> <li>• Ambulatory DME, including canes, walkers, and wheelchairs</li> </ul>

<i>Participant Title</i>	<i>Percentage of Clients that have Medicare</i>	<i>Geographic Area Served</i>	<i>Types of DMEPOS Provided</i>
President	Less than 50% Medicare	Local	<ul style="list-style-type: none"> <li>• CPAP</li> <li>• Complex rehab</li> </ul>
<b>Riverside (6)</b>			
President/Owner	85%	Local	<ul style="list-style-type: none"> <li>• Wound care, orthotics, compression supplies, and incontinence supplies</li> <li>• Primarily retail</li> </ul>
President/Owner	Slightly above 50%	Local	<ul style="list-style-type: none"> <li>• All DME except oxygen and complex power wheelchairs</li> </ul>
Owner/Pharmacist	More than 50%	Local	<ul style="list-style-type: none"> <li>• CPAP/BIPAP, scooters, walkers, wheelchairs, and beds</li> </ul>
President/Owner	20%	Local	<ul style="list-style-type: none"> <li>• All DME except complex rehab power wheelchairs and enteral nutrition</li> </ul>
President/Owner	Slightly above 50%	Local	<ul style="list-style-type: none"> <li>• All DME except diabetic supplies and enteral infusion</li> </ul>
President/Owner	45%	Local	<ul style="list-style-type: none"> <li>• All DME except complex rehab power wheelchairs</li> </ul>
<sup>1</sup> The question about “Percentage of Clients that have Medicare” was added after the Dallas focus group, which was the first of the four, therefore this information is not available for Dallas.			

### 2.3. Key Informant Interviews

We recruited key informants for interviews in each case study CBA. Internet search methods were used to identify, beneficiary advocacy groups, referral agent groups, industry associations, and supplier organizations that might have a broader perspective on the local DMEPOS market, and opinions about the potential impact of the Medicare competitive bidding program. We identified national organizations and then searched for local affiliates in the case study sites. For example, the local offices of the Area Agency on Aging (AOA), AARP, American Association for Respiratory Care (AARC), and similar organizations were identified as potential interviewees. Individuals who were most knowledgeable about DMEPOS and Medicare beneficiaries’ concerns were sought within each of these organizations, including Program Directors, Regional Directors, Branch Chiefs, and in some cases the Director of Governmental Affairs (see Table 5). CMS officials were also interviewed.

**Table 5 Key Informant Interviewees**

<i>Key Informant Type</i>	<i>Organization Type</i>	<i>Organization Focus</i>
<b>Dallas (4)</b>		
Beneficiary Group/Advocacy	Senior Advocacy	<ul style="list-style-type: none"> <li>• Elder rights</li> </ul>
Beneficiary Group/Advocacy	Senior Advocacy	<ul style="list-style-type: none"> <li>• Elder rights</li> </ul>
CMS Official	CMS	<ul style="list-style-type: none"> <li>• Medicare financial management</li> </ul>

<i>Key Informant Type</i>	<i>Organization Type</i>	<i>Organization Focus</i>
Association Board Member	Professional Association	<ul style="list-style-type: none"> <li>• Medical professional advocacy</li> </ul>
<b><i>Orlando (6)</i></b>		
Beneficiary Group/Advocacy	Senior Health Insurance Advocacy	<ul style="list-style-type: none"> <li>• State level advocacy</li> </ul>
Beneficiary Group/Advocacy	Senior Health Insurance Advocacy	<ul style="list-style-type: none"> <li>• Regional advocacy</li> </ul>
Industry Association	Supplier Organization	<ul style="list-style-type: none"> <li>• DMEPOS suppliers</li> </ul>
Referral Agent	Home Health Agency	<ul style="list-style-type: none"> <li>• Case management</li> </ul>
Supplier Organization	Professional Association	<ul style="list-style-type: none"> <li>• DMEPOS suppliers</li> </ul>
Supplier	DMEPOS Supplier	<ul style="list-style-type: none"> <li>• DMEPOS suppliers</li> </ul>
<b><i>Cleveland (4)</i></b>		
Beneficiary Group/Advocacy	Senior Advocacy	<ul style="list-style-type: none"> <li>• Elder rights</li> </ul>
Beneficiary Group/Advocacy	Senior Advocacy	<ul style="list-style-type: none"> <li>• Elder rights</li> </ul>
Referral Agent	Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Case management</li> </ul>
Referral Agent/Administrator	Rehabilitation Facility	<ul style="list-style-type: none"> <li>• Case management</li> </ul>
<b><i>Riverside (5)</i></b>		
Industry Association	Health Trade Association	<ul style="list-style-type: none"> <li>• Home health, private duty companies, DMEPOS suppliers</li> </ul>
Program Manager	Advocacy Organization	<ul style="list-style-type: none"> <li>• Health insurance advocacy and counseling</li> </ul>
CMS Official	CMS	<ul style="list-style-type: none"> <li>• Medicare financial management</li> </ul>
Industry Association	Supplier Organization	<ul style="list-style-type: none"> <li>• California DMEPOS suppliers</li> </ul>
Industry Association	Supplier Organization	<ul style="list-style-type: none"> <li>• National DMEPOS supplier interests</li> </ul>

## 2.4. Comparison Area Informant Interviewees

Internet searches were used to identify beneficiary advocacy groups, referral agent groups, and supplier organizations in the Tampa, Houston, and San Diego metropolitan areas. Professional associations and societies, regional advocacy groups, and regional representatives of national organizations were contacted, as well as large DME suppliers and health care systems.

Recruiting interviewees in these comparison areas was challenging. We initially contacted participants from the 2007 case studies in Tampa and Houston and invited them to participate again. Additionally, internet searches were conducted to identify new potential interviewees. A total of 24 institutions/organizations were contacted in Tampa, and five key informants participated in telephone interviews. In Houston, 51 institutions/organizations were identified; seven agreed to participate in interviews. Despite intensive efforts, only four of these volunteers ultimately participated in the key

informant interviews. Since San Diego was not included in the 2007 report, there were no previous participants to reengage, and all contacts there were new. In the San Diego area, 24 institutions were contacted and six key informant interviews were conducted. Many potential candidates were either totally unfamiliar with competitive bidding for DMEPOS, were unable to get corporate approval to be interviewed, did not have time to participate, or refused to participate.

Table 6 lists the type of organizations whose representatives were interviewed in comparison areas, the organization’s primary focus, and each participant’s title.

**Table 6 Comparison Area Key Informants**

<i>Key Informant Type</i>	<i>Organization Type</i>	<i>Organization Focus</i>
<i>Tampa (5)</i>		
Referral Agent/Administrator	Hospital Home Health Agency	• Case management
Referral Agent	Hospital Home Health Agency	• Case management
Supplier	DMEPOS Supplier	• DMEPOS
Supplier	DMEPOS Supplier	• DMEPOS
Beneficiary Advocate	Nursing Home Advocacy	• Nursing home residents
<i>Houston (4)</i>		
Supplier	DMEPOS Supplier	• DMEPOS
Supplier	DMEPOS Supplier	• DMEPOS
Beneficiary Advocate	Senior Advocacy and Case Management	• Case management
Referral Agent	Hospital	• Case management
<i>San Diego (6)</i>		
Owner	Nursing Home/Rehabilitation Facility	• Case management
Director	Nursing Home/Rehabilitation Facility	• Case management
President	DMEPOS Supplier	• DMEPOS
Supplier	DMEPOS Supplier	• DMEPOS
Beneficiary Advocate	Disability Advocacy	• Disabled people
VP of External Affairs and Gov’t Relations	DMEPOS Supplier	• National DMEPOS

## 2.5. Summary of Recruiting Process

It was challenging to identify individuals who were directly involved in referring Medicare beneficiaries to suppliers for their DMEPOS. Almost all referral agents who assist Medicare beneficiaries with DMEPOS had heard about the Medicare DMEPOS competitive bidding program by 2010, but many did not feel that they knew enough about the program to contribute to a focus groups or interview.

It was equally challenging to identify and recruit key informants with diverse, community-wide perspectives. Few national associations had local affiliates in the CBAs of interest: their affiliates were usually at the state or even regional levels, not at the metro level. In such cases, we sought a state-level affiliate who could offer insights about the city of interest. Even when we located an appropriate organization, we often had difficulty finding anyone familiar with Medicare's DMEPOS competitive bidding program. Several patient advocacy groups and healthcare provider organizations did not have any knowledge of the program and consequently declined to comment on the DMEPOS environment or competitive bidding.

Suppliers were not difficult to identify, and all those we contacted were quite familiar with Medicare DMEPOS competitive bidding, although some declined to participate. In particular, suppliers from chains cited "corporate policy" when declining to join focus groups. We also encountered smaller suppliers that had decided not to submit a bid (and a few that had decided to cease operations), and many of these did not wish to discuss their decisions. As a result, our supplier focus groups and key informant interviews came mainly from larger independent suppliers, most of whom had submitted bids.

Suppliers, referral agents, and others in the comparison areas of Tampa, Houston, and San Diego were less well-informed about Medicare competitive bidding than were those in the CBAs, and it was harder to find knowledgeable individuals with community-wide perspectives who were willing to participate in interviews in the comparison areas. Potential interviewees were not interested in participating if they felt unknowledgeable about the program, or if they were not concerned about the impact of a program that did not directly affect their metro area. Those who were ultimately interviewed were, as with the focus groups, a convenience sample of individuals who agreed to participate, often because they felt strongly about the competitive bidding program. Although considerable efforts were made to incorporate diverse perspectives, the views of these individuals may not reflect those of their peers who were not contacted or who declined to participate.

### **3. Baseline Site-Level Findings for CBAs**

This chapter presents findings from focus groups and interviews with referral agents, suppliers, and other stakeholders in the four study CBAs, including agencies that educate and counsel Medicare beneficiaries and those that represent the interests of suppliers. Attention is focused on issues common to all study sites and actors, where consistent opinions enhance confidence in the findings. Where appropriate we describe variations in perceptions of market conditions, referral processes, and related issues; we also highlight changes in perspectives observed between the data collected in 2007 and in 2010.

The first two sections describe, compare, and contrast study participants' perspectives on referral processes and on the DMEPOS markets in which competitive bidding is being implemented. The third section discusses participants' concerns about the anticipated effects of the competitive bidding program. The fourth section explores suppliers' bid decisions and experiences during the process of submitting bids.

#### **3.1. Current Referral Processes**

Referral agents and suppliers view the current referral process as functional and effective. Referral agents are most concerned about the following factors, and suppliers are aware of these priorities and compete to provide service in these dimensions:

- Patient preferences
- Geographic location and proximity to patient's home
- Ability to provide all DMEPOS products a patient may need
- Acceptance of all/most types of insurance
- Timeliness
- Excellence in patient education

##### **Referral Agents**

Referral agents who participated in focus groups and interviews hold positions as discharge planners and care coordinators in various healthcare settings. Many are social workers and physical therapists, or nurses who coordinate care in home health care agencies. These referral agents work in many types of institutions and organizations, including community hospitals and large medical centers, independent and hospital-based home health agencies, and rehabilitation hospitals and outpatient clinics. Most participants assist Medicare beneficiaries directly in securing appropriate DMEPOS, while others oversee these activities in management and supervisory positions.

Referral agents provide the critical link between medical providers, suppliers, and patients. These professionals receive physicians' orders and contact suppliers to arrange for the necessary DMEPOS. Their responsibilities involve reviewing insurance coverage and other administrative requirements associated with acquiring DMEPOS, and may include completing sections of the Certificate of Medical Necessity, depending on how the referral was processed. In addition, referral agents monitor the timely delivery of equipment and supplies. Those who provide home care or community-based case management ensure patients' proper use of DMEPOS, and deal with problems and complaints related to equipment maintenance and service delivery. Although physicians often write or sign off

on orders, some referral agents with clinical backgrounds evaluate patients' DMEPOS needs. In Orlando, several referral agents advised that all RNs can write orders for DMEPOS if the physician has signed the discharge protocol.

Physicians are not heavily involved in the referral process for basic, non-customized equipment (other than writing prescriptions for DMEPOS). Typically, there is no contact between the physician and the supplier; the referral agent handles all necessary communication. Conversely, there may be closer coordination for complex and custom-fit equipment, at least initially, to ensure that the patient receives appropriate equipment that is properly fitted. In this latter scenario, the referral agent serves as the liaison between the physician and the supplier. Referral agents who are also clinicians (e.g., physical therapists, respiratory therapists) are actively involved in fitting the equipment and ensuring that it is appropriate for the patient, is delivered and set up properly, and functions correctly.

When securing DMEPOS for patients, referral agents report that they consider several issues beyond the equipment carried by the vendor. Key factors include the supplier's track record, patient preferences, and insurance and institutional requirements and policies. In many cases, referral agents have limited latitude in selecting a supplier. Managed care plans have contracts with selected suppliers and require members to use them; this is sometimes true for hospitals as well. The plan or hospital may contract exclusively with one supplier, or offer a choice among a defined group of suppliers. For example, referral agents noted that one of Cleveland's integrated health care systems owns its in-house DME supplier; and one of the largest hospital-owned home health care agencies in the Orlando CBA has an HME (home medical equipment) supplier within its system. One participant added that a physician, such as an orthopedic surgeon, may request that an order be filled by a specific supplier. These designated suppliers may sometimes be among those preferred by a referral agent, but this is not always the case.

Unless insurance or other requirements preclude choice, most referral agents ask patients if they have preferences for suppliers because some patients have existing relationships with specific vendors. These preferences are generally respected if the supplier can meet the patient's needs for the new DMEPOS. Most patients, however, do not have a preference, and rely on the referral agent to select a supplier and arrange purchase and delivery of DMEPOS.

In all sites, most referral agents maintain lists of trusted DMEPOS vendors with whom they have established relationships. When seeking new equipment from a vendor with whom they have no prior experience, referral agents seek recommendations from colleagues. Referral agents and their colleagues regularly share information on supplier performance.

Referral agents most highly value a supplier's ability to deliver equipment in a timely manner, particularly for patients being discharged from the hospital and those in "life and death situations." They place a high priority on service (including patient education) that is reliable and of consistently high quality. Referral agents consider the supplier's service area and proximity to the patient's home, and may give preference to a supplier willing to work outside the usual service area, especially if the patient lives within a reasonable distance. A manager at a major rehabilitation hospital in Cleveland said "we look at the best supplier in that diagnostic category, at the best price." Referral agents do not have different standards for Medicare patients than for others; suppliers providing good value are preferred, regardless of the fee schedules or contracting used by various insurers. Home health agency staffs, in particular, want suppliers who offer extended weekday and weekend hours. For less complex equipment needs or when the patient requires more than one piece or type of equipment,

many referral agents seek “one-stop shopping,” preferring to work with a full-service DMEPOS supplier or one that carries items in more than one product category so that the process is more efficient. A few participants mentioned the importance of working with a dedicated supplier representative, particularly when dealing with large or national suppliers, and with a vendor who has “an efficient system” for communicating, so that multiple calls are not required to place an order or resolve an issue. One of the larger home health agencies in Cleveland, as well as some referral agents in other CBAs, prefers suppliers that accept all types of insurance (including managed care and Medicaid) so they do not have to be concerned about whether a patient’s insurer will authorize payment to a particular supplier.

Procedures and other details of the referral process vary, depending on the type and complexity of the equipment ordered, the care setting and level of care, and other factors. Most hospital-based referral agents report that patients receive products such as wheelchairs and walkers before they are discharged from the hospital. Referral agents arrange for clinical staff (e.g., physical therapists) to instruct patients on the use of this equipment before they go home. For larger DMEPOS, such as hospital beds and complex respiratory equipment that must be set up in the home, discharge planners or care coordinators arrange delivery to the patient’s residence. Hospital-based referral agents typically do not interact with patients about equipment after discharge; that responsibility shifts to home health agencies or others who work with home-based patients.

Home health referral agents work with homebound patients over time to obtain equipment and associated services, ensure patient education in using the equipment, and generally act as intermediaries between the patient and the DMEPOS supplier. As a regular visitor to the patient’s home, the home health nurse or aide knows whether the patient is using the DMEPOS appropriately and if the DMEPOS is functioning properly. When problems are observed, the home health agency nurse contacts the DMEPOS supplier to seek resolution. Home health referral agents also help homebound patients who already have DME equipment at home obtain needed refills or repairs and maintenance.

Referral agents who work in outpatient clinics and rehabilitation hospitals are often physical therapists who order DMEPOS from the appropriate supplier. Outpatient rehabilitation is often post-acute care, and patients must often use complex or custom-fitted equipment. A referral agent in a Cleveland rehab hospital that specializes in spinal cord and neurological cases, traumatic brain injury, and other complex cases explained that some DMEPOS are needed during the patient’s hospitalization, while items needed for home care are usually provided on the day of discharge. Patients benefit from being able to “trial” many different types of equipment as inpatients, because the hospital has so much equipment on hand.

Referral agents who participated in our focus groups reported that current referral processes work well and have over time become more streamlined and efficient. Referral agents have also developed dependable relationships with suppliers over time. Several participants believe that competition among many suppliers has led to better and timelier service, although referral agents continue to encounter challenges with supplier performance. Staff in home health agencies voiced the most frustration, saying that they must be vigilant in monitoring patient education on equipment in the home, as well as equipment maintenance.

Many referral agents raised a concern that restricting Medicare contracts to fewer suppliers could degrade the service-oriented industry that intense competition has generated, and disrupt dependable

relationships developed over a long period of time. Further discussion of this and related issues appears in Section 2.3.

## **Suppliers**

Most suppliers who participated in the focus groups work in small to midsize local, independent businesses. Some have a regional presence; only one representative of a national chain participated. Most participants were owners, CEOs, or managers and many were respiratory therapists, physical therapists, and nurses. In all sites, the majority of participants specialize in oxygen and respiratory products or were full-service providers, while others focus on home care and complex rehabilitation equipment.

Suppliers in all four sites confirmed information provided by referral agents on the sources of referrals for DMEPOS products and services. Focus group participants added that word-of-mouth, particularly in the form of recommendations from other beneficiaries, provides a small but gratifying source of business. At the present time, suppliers stated that referral patterns work well in their communities.

## **3.2. The DMEPOS Market and the Environment for Competitive Bidding**

Focus group and interview participants' perspectives of the DMEPOS market and other features of their respective CBAs provide valuable information for understanding the context in which Medicare competitive bidding is being implemented. Several market factors may be affected by, and may help to explain, the outcomes of competitive bidding, including:

- the geography, size and rurality of competitive bidding CBAs
- the number of and competition between major medical centers in the CBA
- the influence of health insurers (Medicaid, managed care, etc.) and their use of competitive bidding and other contracting mechanisms
- the abundance of suppliers and degree of competition among them.

### **Referral Agents**

Referral agents in all CBAs were more aware of the program in 2010 than they were in 2007. In all sites, suppliers are the most common source of information about the program, keeping referral agents advised about the progress of Medicare's competitive bidding program. Other referral agents have received communications from their employers and from professional associations. Most referral agents understand that suppliers they now prefer may or may not be able to continue serving Medicare clients, and most anticipate that this will alter existing relationships with suppliers, may create difficulties in the referral processes, and may have other negative impacts. Nonetheless, referral agents know little about how the program will work and when it will go into effect. For example, none of the referral agents understood how and when they will be notified of the winning suppliers in their markets.

With a few notable exceptions, referral agents in all sites agreed that the number of suppliers for all types of DMEPOS is currently sufficient. For the most commonly used items, such as wheelchairs, walkers, oxygen, and other respiratory devices, the options are plentiful. This judgment echoes

assessments made by referral agents during group discussions held in 2007. That said, referral agents in 2010 emphasized that the exceptions, which relate mainly to the availability of more highly specialized equipment and suppliers who serve rural areas, are very important. For example, several referral agents in Riverside indicated that there are only one or two companies that provide wound vacs in this very large, two-county CBA. Although current supplier availability in more rural parts of the CBA is perceived to be adequate, referral agents reported that they are deeply concerned that beneficiaries will be put in jeopardy if all or most of the vendors in these underserved areas are not awarded bids. Concerns about rural access to DMEPOS may reflect misunderstanding of the program and special protections for low-density and rural areas.<sup>2</sup> Referral agents also expressed a broader concern about the potential downsizing of the supplier market (discussed in more detail in Section 2.3).

Referral agents state that suppliers compete for business primarily on quality, timeliness, reliability and overall customer service -- all factors that drive selection decisions. More specifically, referral agents report that suppliers compete by highlighting their ability to:

- 1) Deliver and set up DMEPOS in a timely manner (e.g., at the time the discharged patient returns to her/his residence);
- 2) Offer high quality, reliable DMEPOS products;
- 3) Provide instruction to patients on the proper use of equipment (viewed as particularly important for oxygen therapies); and
- 4) Respond quickly to requests for maintenance and repair.

Some suppliers distinguish themselves by promoting their acceptance of many insurance plans, including managed care plans and Medicaid. Referral agents believe that most suppliers offer similar products at comparable prices, and cost is not an important competitive factor.

Referral agents offered brief comments on the characteristics the DMEPOS markets in their CBAs, including access to and quality of equipment, the level of competition among suppliers, the presence

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<sup>2</sup> The competitive bidding law prohibits conducting competitions in rural areas before 2015. Section 1847(a)(1)(B) of the Social Security Act (the Act) requires that both the Round 1 rebid and Round 2 occur in large metropolitan statistical areas. Furthermore, section 1847(a)(1)(D)(iii) of the Act requires the Secretary to exempt rural areas from subsequent competitions occurring before 2015 (except for national mail order). The statute also gives CMS discretionary authority for exempting low population density that are not competitive based on one or more of the following indicators:

- Low utilization of DMEPOS items by Medicare beneficiaries receiving fee-for-service benefits relative to similar geographic areas;
- Low number of suppliers of DMEPOS relative to other similar geographic areas; and
- Low number of Medicare beneficiaries receiving fee-for-service benefits in the area relative to other similar geographic areas.

This discretionary authority was used to exempt large portions of Eastern Riverside and San Bernardino Counties in the Riverside MSA, as well as whole counties in the Dallas, Cincinnati, and Kansas City MSAs. CMS determined that these areas had population densities that were too low relative to other parts of the MSA and that the allowed charges for DMEPOS items attributed to these areas were low relative to the MSA as a whole, indicating that the areas were not competitive when compared to other parts of the MSA. See CMS details at: <http://www.hhs.gov/asl/testify/2008/05/t20080521d.html>

of dominant suppliers, and other impressions of the current supplier industry in their respective areas. These observations help to explain the overall environment for competitive bidding.

**Dallas:** Focus group referral agents characterize the DMEPOS market as very competitive, with suppliers competing more on service than on price. The multitude of suppliers competing for market share has led to extremely aggressive marketing by some companies in this largely urban CBA.

Dallas has enough suppliers that, as one referral agent observed, “If we’re not satisfied with a company, we can change.” Many problems cited by participants relate to timely delivery. As was true in 2007, suppliers located closer to a patient’s residence have a competitive advantage because Dallas is so large that proximity enhances timeliness. One referral agent who serves patients from Houston and Louisiana offered that “we need a company that can cross state lines.” Suppliers must also achieve a high level of patient satisfaction: “if the same complaint gets reported repeatedly, then we drop that company.”

Referral agents identified occasional challenges in accessing specialty items, such as nutritional supplies, customized beds, and liquid oxygen.

Some Dallas professionals reported past fraud problems with “a lot of companies [that] aren’t really companies,” and those that exaggerate claims about the availability of working equipment, delivery schedules, and the extent to which they follow through with patient education in the use of equipment. One referral agent encountered a language barrier with some suppliers’ employees. One participant who deals mainly with referrals for oxygen said, “I look to see if companies are promising things they can’t do.” Another has attempted to alleviate her concerns by visiting suppliers to ensure that the company has a good supply of new equipment, and by gathering information annually on the number of complaints lodged against suppliers. For these reasons, Dallas referral agents prefer to work with suppliers they have had good experiences with for some years, a preference echoed by their peers in Cleveland, Orlando, and Riverside.

**Cleveland:** Referral agents in Cleveland describe the market for DMEPOS as “extremely competitive.” Cleveland is a major center for medical care in northeast Ohio, with a lot of competition among the many highly regarded hospitals and clinics, some of which have in-house DMEPOS operations. Focus group referral agents feel that there is a good mix of local, regional, and national DMEPOS suppliers to meet their needs. A director of therapy services at a prominent rehabilitation hospital, a major user of orthotics and prosthetics, said that these items are available only from a small number of specialty suppliers.

Referral agents in Cleveland believe that the area has an adequate number of suppliers for the different product categories, although they mentioned that bariatric equipment can be difficult to get, as are standard types of equipment for people with unusual physical characteristics, such as “a walker for a six foot seven inch man.”

**Orlando:** Referral agents in Orlando believe their area has more than enough suppliers for most types of DMEPOS, and that there is considerable competition among suppliers. While most focus group referral agents said that there are in fact “too many” suppliers, a director of one of the largest home health care agencies in the CBA (who was interviewed separately) remarked that while there is an oversaturation of suppliers in south Florida, this is not necessarily the case in Orlando and other parts of central Florida served by her company.

As their peers reported in focus groups held in 2007, Orlando referral agents in 2010 stated that there are a few dominant suppliers for oxygen equipment and for CPAP devices; however no supplier leads the market in most other DMEPOS. One referral agent identified a dominant supplier for negative wound pressure therapy systems.

Despite the overabundance of suppliers who provide most DMEPOS, focus group participants, most of whom work in home health care, are not entirely satisfied with the service that some vendors provide. The abundance of suppliers does not mean that their needs and expectations are met. Dissatisfaction centers, in large part, on customer service and patient education. Not all suppliers follow through, so the home health nurse must make a special trip to ensure that the patient uses the equipment properly.

Referral agents also report that some trusted suppliers cannot handle more business; referral agents must continuously build new relationships. Referral agents in Orlando, and those in other CBAs, want options for themselves and their patients if suppliers are unable to process quick-turnaround requests, become overextended, or underperform in other ways.

**Riverside:** Referral agents perceive that the DMEPOS market in and near Riverside is served by an adequate number of suppliers. One referral agent in a large, hospital-affiliated home health agency has found “no gaps for products and no problems in accessing supplies.” She added that, especially for oxygen, “there are many vendors to choose from.” The availability of DMEPOS comes with a *caveat*: one referral agent added that “it depends [on] what you want.” There are few suppliers for specialty items such as ventilators, tracheotomy supplies, and complex rehabilitation power wheelchairs, although most of these specialty items are not subject to round one of competitive bidding. Availability of a diverse array of equipment and suppliers, whether basic or complex, is not as dependable in the more rural, sparsely populated areas in this “sprawling” and geographically diverse CBA. Although supplier services are sufficient at this time, referral agents fear that any change in existing patterns could put rural beneficiaries at risk.

Referral agents give suppliers mixed reviews: some are very satisfied, while others are more critical. “By volume there are plenty, but in terms of timely, reliable, and efficient suppliers, there’s a small pool to work from, especially [those who provide service on] weekends.” Maintenance was described as often “haphazard.” Furthermore, one participant observed that, in the past, “there were many start-up companies and some seemed shady,” although this has improved.

Participants widely agreed that one dominant, full-service supplier (a well-known national chain with a MediCal contract), “has gotten sloppy, since they’re guaranteed so much business.” According to these agents, the company in question can bid lower than the smaller suppliers due to its volume advantage, and is perceived by referral agents as being less responsive.

The marketing of supplier products and services described by referral agents in 2010 mirrors the methods suggested by participants in 2007. Referral agents in each site explained that suppliers promote their products and services directly, mainly through face-to-face meetings with staff or management, seeking to be added to existing lists or to be retained on lists. Suppliers’ marketing methods often involve lunch or refreshments at meetings; pens, magnets, and small office supplies; gift cards for coffee; and “meet and greet” sessions with staff. Cleveland is the only one of the four study sites in which referral agents mentioned that suppliers sometimes offer free medical supplies,

such as diabetic test strips and other “clinical extras.” Most interactions between suppliers and referral agents occur during regular meetings at the organizations/institutions in which referral agents are employed.

Referral agents in Riverside and Cleveland reported that marketing also occurs indirectly through in-service sessions for staff, which usually focus on the introduction and use of new equipment. These referral agents also mentioned that some suppliers occasionally sponsor continuing education credits (CEUs) for staff and other educational activities at the vendors’ facilities. Referral agents believe that educational programming by suppliers is very beneficial for their staff, as well as being an effective marketing tool for suppliers. In addition to routine marketing activities, referral agents occasionally learn about supplier services and equipment at professional meetings, where local suppliers and representatives of national companies distribute material at booths.

Many referral agents mentioned that their institutions have firm parameters within which marketing activities can be conducted. One hospital-based discharge planning nurse in Orlando said “we limit marketer time to 15 minutes, once a week.” Referral agents do not permit suppliers to market directly to beneficiaries in inpatient or outpatient settings, and this strict “no solicitation policy” is strongly enforced. Some Medicare beneficiaries do interact directly with suppliers at community health fairs and senior centers.

## **Suppliers**

Suppliers’ assessments are very similar to those of referral agents with respect to the competitive nature of the DMEPOS market in each of the four CBAs, the challenges of serving large geographic service areas, and the availability and quality of DMEPOS equipment and services. Suppliers also share referral agents’ concerns about competitive bidding’s interference with the referral process and “the relationships that most people have. It fragments the referral process.”

In general, suppliers agreed with referral agents’ descriptions of the availability of different product categories and areas in which capacity and services are currently limited. Suppliers provided additional perspectives: for example, a supplier in Riverside believes that “the desert region is currently underserved for complex rehabilitation power wheelchairs, because several [companies] have closed in the past year from financial duress.” In Orlando: “there’s an overcapacity of wheelchairs, oxygen, CPAP, and there’s an undercapacity of urologicals, nutritionals, [and] mastectomy” supplies. These comments reiterate referral agents’ concerns about the ability of area suppliers to meet the need for complex or specialty equipment. It is important to note, however, that most of the specialty products referral agents voiced concerns about are excluded from round one of competitive bidding.

Suppliers in each CBA emphasized that they compete not only on price but on service. They believe that the critical importance of service, and specifically patient instruction, has been under-appreciated in the move toward competitive bidding.

Suppliers’ perspectives on specific market characteristics and functioning in the CBAs were somewhat difficult to discern, because their comments were tightly intertwined with their very negative views about Medicare competitive bidding. Their opposition is strong and influenced by several factors, including: across the board cuts in Medicare payment rates for DMEPOS two years ago; fallout from the first round of competitive bidding in 2007 during which (these suppliers

asserted) some small firms went out of business; and the potential impact of the upcoming program. Suppliers' insistence on conveying these views during focus groups made it very difficult to steer the conversation toward other aspects of these individual markets. For example, in Dallas, Cleveland, and Orlando, suppliers held negative views about competitive bidding in general; only in Riverside did suppliers discuss their particular CBA and whether it is an appropriate Round One location for competitive bidding, and they appeared to be unaware that the most rural portions of the CBA were exempted by CMS from round one of competitive bidding.

*“There are sections of the CBA that are not a good area because of their remoteness and their access. By limiting or potentially eliminating any local supplier in those areas, that puts the communities at risk. The corridor [between the western border of Riverside County and the city] and the more urban areas are probably OK.”*

Suppliers describe how they generally lose money on some products, and can make it up on others. Their ability to balance things out in this manner has changed dramatically with the recent price cuts by Medicare and by managed care plans. Only in Riverside did a supplier suggest that there is perhaps some additional room for negotiating prices in a product category: orthotics.

Like their counterparts in the 2007 groups, focus group participants in 2010 were mainly from smaller, independent suppliers. They reported that it is difficult to compete with large suppliers, particularly those owned by national chains, who buy in bulk at reduced prices. They also view the large/chain suppliers as offering lower-quality products. The pricing and contracting practices of large managed care plans, and the pressure these place on small suppliers in particular, are prominent issues in Riverside and Dallas, where managed care plans have a strong presence. Suppliers fear that Medicare competitive bidding will similarly drive bids so low that companies can no longer maintain excellent products and customer service.

Suppliers participating in focus groups cited the same example to illustrate their point about reduced service: the provision of a respiratory therapist to assist patients in setting up and using equipment relating to respiratory therapy. Payment rates must be sufficient to cover the therapist's time, but managed care plans have negotiated such low reimbursement rates that suppliers may no longer be able to pay for the therapist. Most suppliers fear that the same will happen with Medicare competitive bidding, and that Medicare patients on oxygen equipment may lose access to respiratory therapy. Suppliers who expressed this concern may not have been aware that CMS requires suppliers to provide access to respiratory services as needed by the beneficiary, that meet relevant standards in the American Association for Respiratory Care Practice Guidelines (although respiratory therapy itself is not part of the DME oxygen benefit and cannot be billed separately under Part B).

Discussions with suppliers in Riverside produced additional comments about the nature of that CBA, where geography presents more challenges than in the other areas studied. These challenges stem from its size, the rural nature and remoteness of some parts of the county, traffic patterns (particularly east of Riverside), and mountain road conditions. Suppliers suggest that, under the best conditions, it takes four to five hours to drive between the two sides of the Riverside CBA. There are rural parts of this CBA where all Medicare beneficiaries are served by a single supplier. One focus group participant reported that he is the only supplier within 100 miles of his location. Again, these suppliers may be unaware that CMS exempted the most rural portions of this CBA from round one of competitive bidding.

## **Other Stakeholders**

Key informant interviews with a range of organizations garnered other stakeholder perspectives on the DMEPOS marketplace and issues related to Medicare competitive bidding.

### ***Beneficiary Organizations***

We interviewed representatives from Senior Health Insurance Programs (SHIPs) in Riverside and Orlando. These agencies provide education, counseling and advocacy services to Medicare beneficiaries; they train volunteers, and as one manager said, they are “the face of Medicare help in the region.” Representatives from Area Agencies on Aging (AAA) in Cleveland and Dallas also shared their views.

The SHIP in Riverside offered detailed information about that market, much of it consistent with the perceptions of referral agents and suppliers. Briefly, staff in this organization believes it is difficult to meet patient needs for highly specialized or custom fitted equipment. Otherwise, many brands and products are available, and the agency hears very few complaints about quality from Medicare beneficiaries. Fortunately, referral agents and beneficiaries have a lot of choice in suppliers for the most commonly used DMEPOS. A few large, national suppliers operate in the area, and there are many smaller “mom and pops,” especially in the rural areas. One informant estimates that large companies control perhaps 50% of the Medicare DMEPOS market, and their business is focused in the “main city hubs” of the CBA: Riverside, Temecula, Victorville, San Bernardino, and Palm Springs. She named one of these suppliers as a national chain identified by both referral agents and suppliers in our focus groups. She also confirmed that there is a strong presence of Medicare Advantage plans and HMOs in the CBA. The SHIP in Orlando reported that suppliers are spread throughout the state, and there is a dominant DMEPOS supplier only in one of the counties served by the agency. These informants did not have a clear sense of the adequacy of the supplier industry’s ability to meet beneficiary and referral agent needs in their CBAs, but they are aware of marketing efforts through health fairs, sponsored events, and “meet and greets.”

The involvement of the AAAs in procuring DMEPOS for Medicare beneficiaries in Cleveland and Dallas is one element of the short-term case management they provide on behalf of clients 60 years of age and older. These agencies assist their clients in finding and paying for DMEPOS before they are eligible for Medicare. The AAA is the “payer of last resort,” and the staff is very knowledgeable about insurance options, particularly those for Medicare-Medicaid dual eligibles. AAA representatives confirmed that there is an adequate mix of large and small suppliers in both Cuyahoga County (Ohio) and in the Dallas metro area. The quality of service they provide is seen as very good, and because prices of DMEPOS are similar among different suppliers, timely delivery is usually a deciding factor in selecting a supplier.

### ***Supplier and Trade Groups***

An interview with a California trade organization that represents companies that provide home health care products and services offered a perspective on the pressures that exist between Medicare and Medicaid (MediCal). This issue was not discussed in great detail with other participants, but some alluded to complications that arise for dual eligibles, which they suspect will become more complex as competitive bidding proceeds.

*“There are disconnects in how the state pays for medical supplies...In certain areas of California, home health agencies can’t find any [suppliers] who are willing to supply certain*

*types of supplies for the state rates. This is an issue pre-competitive bidding and it has to do with how MediCal reimburses for medical supplies.”*

### **3.3. Anticipated Effects of Competitive Bidding on Referral Processes and the DMEPOS Market**

Focus group and interview participants expressed strong concern about the effect of Medicare competitive bidding on provision of DMEPOS to Medicare beneficiaries. Participants did not acknowledge any area in which competitive bidding would have a positive effect. Participants instead focused on the potential for deleterious effects on:

- Referral processes and relationships among referral agents, patients, and suppliers
- Availability and quality of service and access to equipment
- Beneficiary health
- Supplier relationships with beneficiaries
- The structure of the supplier industry
- Suppliers and local economies

Participants further pointed out how the Medicare competitive bidding program might influence pricing for DME equipment and services by managed care plans and by Medicaid.

Many views expressed by participants in focus groups and interviews conducted in 2010 are consistent with those reported in 2007. That said, events of the past few years, including the 2008 10% fee reduction, have focused more attention on Medicare payment.

#### **Referral Agents**

Referral agents in our focus groups expect that Medicare competitive bidding will affect referral processes in many ways, and that it will make their jobs more difficult. It is much more straightforward and efficient to arrange all of a patient’s DMEPOS needs with one supplier, rather than having to use different suppliers for different products. If a supplier who carries a patient’s DMEPOS does not receive a contract for one or all of the product categories the patient needs, referral agents (and beneficiaries) will be forced to use multiple vendors. Referral agents believe that this will disrupt existing relationships with trusted suppliers that have been developed over time and with much effort, and will increase the time needed to monitor training and patient education provided by new suppliers. Referral agents fear that customer service, including patient education, will be degraded. They are especially concerned that some suppliers may be unable to afford to employ respiratory therapists to train patients in using oxygen equipment.

Another challenge referral agents expect to face as Medicare competitive bidding takes effect involves transitioning patients from one supplier to another. Presently, when home health nurses request refills or repairs for their clients’ DMEPOS equipment, their patients often do not know which supplier originally furnished the equipment. Referral agents attempt to identify the original supplier; when that is not possible (or if that first supplier has gone out of business), the nurse must find a new supplier willing to assume responsibility for the case. If competitive bidding drives some

suppliers out of the market altogether, more patients will require assistance in navigating these transitions.<sup>3</sup>

Referral agents are also concerned that high-quality DMEPOS products will be replaced by products of lesser quality when competitive bidding begins, and that the services required to ensure the proper use and functioning of DMEPOS will suffer. Less timely equipment delivery for patients being discharged from the hospital is predicted in all CBAs, and referral agents project that hospital length of stay will increase when equipment is not available when the patient is ready for discharge. A similar concern was raised for home care patients. A referral agent in Cleveland said that if this were to happen in her hospital, and the length of stay exceeded the appropriate discharge date, the institution “would have to eat the cost.” (Note: This comment reflects an incorrect understanding of the Medicare DRG payment system, which imposes no limitations on length of stay for Medicare patients.)

Referral agents in all four CBAs speculate that competitive bidding could present difficulties for smaller DMEPOS suppliers that might not be able to take advantage of volume purchasing to compete effectively against larger firms. Some referral agents stated that small suppliers are more heavily dependent on Medicare than are larger suppliers, and would therefore be less able to survive without a Medicare contract. (No referral agents mentioned the Medicare provision that one-third of contracted suppliers in each CBA are to be small businesses.) One referral agent in Cleveland underscored the fact that any job loss in northeast Ohio is problematic, given recent severe economic and employment problems. Any potential loss of suppliers who serve small segments of the Medicare population could also have serious consequences. Additionally, if there are “too few” winners, those suppliers could become over-extended and unable to meet the Medicare demand for DMEPOS.

Referral agents mentioned only a few potentially positive effects of competitive bidding. The process could further weed out disreputable suppliers; although comments related to fraud in the supplier industry seem to indicate that this is not a substantial problem. A few mentioned possible cost savings for beneficiaries; as the prices of equipment and supplies drop, beneficiary costs in the form of co-payments and co-insurance, should decline as well.

## **Suppliers**

Medicare competitive bidding is a highly charged issue for suppliers, and they are consistently pessimistic about its potential effects. DMEPOS suppliers raised most of the same concerns as referral agents (as did suppliers in 2007), but suppliers are decidedly more critical and emphatic in expressing negativity about the concept of competitive bidding.<sup>4</sup>

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<sup>3</sup> Grandfathering will protect patients whose suppliers continue to operate; referral agents in 2010 did not acknowledge this provision, and may not be fully aware of it. Any beneficiary in a CBA who is receiving oxygen or renting DME from a non-contract supplier that elects to be a grandfathered supplier may continue to receive the item from the grandfathered supplier or begin receiving the item from a contract supplier. A grandfathered supplier cannot turn away a beneficiary if he or she elects to continue receiving the item from the grandfathered supplier. See CMS details at: <http://www.dmecompetitivebid.com>

<sup>4</sup> Although focus groups and interviews did not seek to explore suppliers’ opposition to the concept of competitive bidding, it was front and center in many discussions. Suppliers alluded to organized efforts by suppliers in some CBAs and by some professional organizations, to encourage their elected representatives to

Suppliers in all four CBAs asserted that winning bidders will be selected based primarily on price; they do not believe that service quality and capacity will receive adequate consideration, and they do not understand – and are skeptical about – the ways that factors unrelated to pricing will be considered in the bidding process. Suppliers in each group emphasized the importance of service as a key aspect of their business, and they question whether they will be able to maintain quality and service standards in the face of reduced reimbursement.

Suppliers are convinced that numerous smaller, independent suppliers – especially the “neighborhood” and “mom and pop” companies – will be driven out of business by competitive bidding because most are heavily dependent on Medicare and cannot take advantage of volume pricing like the large chains. Only one or two suppliers briefly mentioned that some small suppliers will be protected by the “30% rule,” whereby 30% of contracted suppliers in each CBA are to be small businesses. (None of the referral agents or suppliers mentioned the provision that allows small suppliers to form networks for bidding purposes.) Many suppliers say that they may need to consider merging with other companies, restructuring their businesses, and laying off customer service and clinical staff, whether or not they win bids. They also point to the impact that the loss of jobs would have in an already difficult economy.

Suppliers agree that the bidding program will result in lower prices for Medicare; however, they believe that the program will reduce competition in the market, which has been the driver of s high service quality. The end result may be degradation in the quality of both service and equipment.

#### Concerns about Service:

Suppliers foresee that equipment delivery will be less timely when there are fewer Medicare suppliers serving a large geographic area. Suppliers in all sites commented that patients may have fewer follow-up visits by suppliers, limited or insufficient training on proper use of equipment, and reduced access to specialized equipment. In addition, suppliers envision that some companies will “drop ship” equipment, essentially mailing or leaving equipment and supplies at the beneficiary’s doorstep, without providing the necessary instruction. Focus group participants in Riverside are especially concerned about services provided to patients in their homes, given the size of the CBA, the remoteness of many small communities, and the small number of suppliers that currently service those areas.

Suppliers are particularly sensitive to what they say is a mischaracterization of the DMEPOS industry as commodity purchasing—a perception that ignores the service that accompanies these products. For example, many focus group participants provide oxygen that may require consistent and frequent servicing. Additionally, suppliers in each focus group referred to the many hours of instruction and service needed to fit oxygen or complex rehabilitation equipment to meet patient needs. They believe that reimbursement rates do not adequately reflect this aspect of patient care.

Concerns about Equipment: Suppliers in each CBA are concerned that even if they win a Medicare contract, they will need to buy less expensive equipment, and perhaps purchase products made

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sponsor legislation that would stop competitive bidding before it starts. Abt Associates’ researchers did not pursue detailed information about these efforts.

overseas (e.g., China and Taiwan). They believe that Medicare will, for many product categories, be paying for lower-quality products that are more likely to break down.<sup>5</sup>

Suppliers also mentioned product-specific effects. For example, there are different types of CPAP equipment, some more effective and reliable than others, which are sold at different price points. Winning bidders who submit low bids will have no choice but to provide the cheaper models. This will in turn encourage more of the “big box store” model: lower prices for inferior products and limited service. CPAP, oxygen, and other respiratory devices are examples of critical and/or complex equipment. Suppliers explained that many patients, especially the elderly, require continuous re-education and monitoring when using these items. Suppliers predict that education and training will diminish under competitive bidding.

#### Concerns about Coordination:

Suppliers, like referral agents, expect that obtaining equipment will be more complicated for beneficiaries, who may have to use several different suppliers to get the products previously provided by one supplier. Suppliers also expect that transitions from one supplier to another will be accompanied by interruptions in service, which at best is inconvenient, and at worst, life threatening. One participant in Dallas predicted that problems will occur when more than one supplier provides equipment or supplies from different product categories that are typically coordinated – e.g., power wheelchairs and their various component parts. Items may not work together properly or, as a supplier in Orlando anticipates: “equipment is going to come on different days.”

**Concerns about Cost:** Suppliers further believe that competitive bidding will be administratively costly for all parties. Participants in all sites suggest that a better way for Medicare to achieve savings is to further lower Medicare fee schedules. If this were to occur, suppliers could simply decide whether to accept these prices.

Finally, suppliers believe there are alternative mechanisms Medicare can use, with proven results, to reduce fraud in the industry and control costs. More-stringent quality standards, state licensing laws, and accreditation have been, and will continue to be, effective. Suppliers maintain that fraud in the industry is now highly overstated, although they support ongoing efforts to control it. They believe that these approaches, combined with reduced reimbursement rates, would have accomplished all of Medicare’s goals without competitive bidding.

### **Other Stakeholders**

#### ***Beneficiary Organizations***

Representatives from beneficiary service organizations raised consistent concerns about the potential impact of competitive bidding. All agreed that heightened confusion is their primary concern, especially during the transition, and for the frail individuals who require DMEPOS and complex rehab. Respondents explain that some beneficiaries will think that competitive bidding will affect their equipment when it will not, and “snowbirds” in California and Florida will not be clear about their coverage for DMEPOS. Confusion also will be accelerated because changes will occur at the

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<sup>5</sup> No study participants mentioned CMS’ plans to require regular reporting of makes and models of products by contracted suppliers as a means to identify the reductions in product offerings, or the fact that contracting suppliers are forbidden by law from discriminating in their product offerings between Medicare and non-Medicare customers.

same time (January 2011) as annual Medicare Advantage and Part D enrollment. The SHIPs report that they will focus on this issue as part of their annual educational programs. The SHIPs are aware that CMS plans an education and outreach campaign to assist beneficiaries, families, referral agents and others in navigating the transition to the newly contracted suppliers.

There is concern that any change in service may lead to postponed maintenance or noncompliance with doctors' orders, and that beneficiaries might not use their equipment and supplies properly (e.g., if their diabetic supplies do not arrive on time from the new supplier, they may not get their glucose monitors calibrated and not check their blood on schedule, because they want to preserve test strips).

A bilingual community educator at one of the SHIPs will focus his efforts on countering some of the unique problems that may arise with the large Hispanic/Latino population in his CBA. These beneficiaries are less likely to change suppliers if their current vendors no longer provide Medicare DMEPOS under competitive bidding. Because this population views its medical providers as “family” and because “trust and loyalty” are deeply ingrained values, these beneficiaries may choose to maintain their loyalty to a DMEPOS supplier even if it requires them to pay out-of-pocket for Medicare covered items that they may not be able to afford. In addition, some may purchase equipment in Mexico and will not be familiar with a local supplier that they trust should problems arise (although any willing supplier can provide repair services). This community educator plans to conduct outreach and education in recognition of these issues.

### ***Supplier and Trade Groups***

Representatives of these organizations raised a concern that small suppliers may not be able to compete against large industry chains, and without small suppliers, there may be an impact on Medicare patient access, at least in some areas. Again, these representatives did not acknowledge the small supplier provisions on the program.

## **3.4. Supplier Bid Decisions and Interactions with CMS**

Competitive bidding has been a closely watched issue because it so critical for the industry. All but three suppliers who attended focus groups in 2010 had submitted bids for the aborted 2007 round of competitive bidding, and did so again this year. Suppliers compared the bidding process in 2010 with their experiences in 2007, and discussed their rationale for deciding to bid, how they arrived at their bid prices, and CMS transparency and clarity.

(Note: The case study in Dallas was conducted in June 2010, just before CMS posted the winning bid prices; suppliers did not yet know whether or not their bids were successful. Case studies in Cleveland, Orlando, and Riverside occurred just after the announcement, which led some suppliers who had not made the price cut, to assume that they had lost their bids.)

### ***Bid Decisions***

In general, suppliers stated that they submitted bids because their businesses are substantially dependent on Medicare. They bid on all items that they currently provide, although a supplier in Cleveland elected not to bid on enteral nutrition supplies. “It wasn’t worth the time to fill out the

paperwork. The price would be so low that it wasn't worth it." In contrast, a Dallas-based supplier revealed that he bid on all product categories because he hopes to expand his business regionally and felt that CMS would find this bid strategy appealing, increasing his chances of "winning the bid."

All suppliers hope to retain business with Medicare, but believe that they will operate with greater risk under competitive bidding. A supplier in Cleveland characterized his bidding approach as "suicide bidding [where] you know you can't really [provide the equipment and service] for that price, but you don't want to lose this business, so you decide to go another 5% lower." Another in Orlando said: "I can't do the CPAP that I've won because you can't buy the products for what they reimburse you." Perceptions of increased risk also stem from difficulty in correctly pricing their bids since volume is not guaranteed and is hard to predict. They were unable to anticipate volume in setting their prices, or whether their competitive market would include far fewer suppliers in 2010 (and hence more volume for each).

A few participants repeated a well-understood business strategy: they cross-subsidized, so that profits on some items might make up for losses on others. They caution that small profit margins will make this strategy less possible in future rounds of competitive bidding.

Suppliers from Riverside and Cleveland (one with more than 50% Medicare business, and the other with less than 50%) explained their reasons for bypassing Medicare competitive bidding altogether, and what they think will happen as a result.

*"They're paying you less than you have to pay for your billing, your accreditation, [and] paying for your staff to do training. There is so much in the way of hidden costs that I didn't see it as being cost effective. I'm thinking of getting out of the Medicare business. We're largely retail, so it's more feasible for us than others who rely more heavily on the reimbursements."*

*"It would have cost more to bid than the advantage that I would get... the cost was prohibitive. I will lose Medicare business and I won't be happy about it, but the way my business is structured, it didn't make sense. I can see that my business won't be affected as much as others [here], but it will be affected because of the patients I already have. I'm not sure I will be able to supply the products to them anymore...I will also lose new Medicare business."*

### ***Bidding Process***

Suppliers stated that the process of submitting bids went more smoothly in 2010 than in the aborted first round of competitive bidding: "it was much better this time than last time." Nonetheless, many found it difficult and, in the assessment of one supplier, "grueling." Focus group participants in 2007 portrayed competitive bidding in that earlier round as "a disaster." Among other problems, they reported that the implementation contractor's website crashed repeatedly during the first few weeks of the bidding process and that there were other programming glitches. In contrast, suppliers in 2010 encountered few technical problems. They reported that the entire process was more organized, and that CMS had greatly improved its information and communication systems for interacting with vendors. In addition, they said the process was easier because CMS did not require as much detailed information on equipment model names, codes, and numbers.

Although suppliers offered some praise for the efforts of CMS, they were highly critical of CMS staff's performance in answering questions clearly and in offering anything more than "canned answers" and "dancing around questions, not answering them." Many agreed with one supplier's comment: "They said they would e-mail back with an answer, and they never did. This was for questions about the bidding process...not complex questions." On a positive note, some suppliers commented that the CMS website is fairly comprehensive, well-organized, and reasonably easy to use. Suppliers' information needs were further met by seminars and other communications on competitive bidding sponsored by their own companies, by trade organizations, and by consultants.

Suppliers reported that many aspects of the bidding process are not at all transparent. They remain unclear about how bids are evaluated, how the capacity to deliver services dependably and in a timely manner is measured, and how CMS weighs quality, price, and other critical factors. Moreover, suppliers did not fully understand the timing of steps in the process, including how and when they will learn if they have been awarded contracts.

Some suppliers in Riverside reported that they turned some or most parts of their bid applications over to consultants or "consortiums" that recommended bid prices. One of these suppliers reported having "consortiums from Florida" approach him to offer assistance. (We did not get a clear sense of how frequently these suppliers and those in other CBAs used these consultants, nor did we explore their influence on the bid process. Based on comments in Riverside, it appears that consultants have been very active in that CBA.) It was reported that consultants, particularly in Riverside, may suggest the same prices for multiple bidding suppliers in a CBA, thereby influencing the bidding process.

### ***Evolving Justification for Competitive Bidding***

Suppliers in 2007 stated their belief that the motivation behind the bidding program is the desire of the federal government and CMS specifically to limit fraud and abuse within the industry. (Many participants failed to understand that competitive bidding is a legislative mandate.) Suppliers in 2010 believe that the federal government's focus has now shifted to cost savings for the Medicare program. Only a few acknowledged that reducing beneficiary out-of-pocket costs is another primary objective. Suppliers believe that the competitive bidding program unfairly makes all suppliers pay for the fraudulent behavior of a few, and that CMS could find other, more targeted, methods to address fraud. They reiterated many times that further cost cutting is impossible without unacceptable reductions in the quality of services and equipment.

## 4. Baseline Site-Level Findings: Comparison Areas

Three comparison sites were chosen for study, based on their similarity to the four study sites. Houston was selected as a comparison site for Dallas, TX; Tampa as a comparison site for Orlando, FL; and San Diego as a comparison site for Riverside, CA. Understanding the DMEPOS markets in comparison communities, and how those markets change over time, will provide an important perspective for interpreting changes in the competitive bidding communities. As described in this chapter, we observed few differences between the CBAs and their comparison sites. The consistency between the CBAs and their comparison sites will reduce the possibility that changes observed in the competitive bidding communities that are unrelated to competitive bidding will be inappropriately attributed to competitive bidding.

### 4.1. Comparison Site Findings

Houston, Tampa, and San Diego will be in the second round of DMEPOS competitive bidding (after 2011); this was announced before our baseline data collection, and many interviewees in these comparison areas were already aware that they too will soon be adjusting to Medicare competitive bidding.

#### 4.1.1. Current Environment for DMEPOS and Access to Products and Services

##### Referral Agents

Referral agents in Houston, Tampa, and San Diego reported similar referral processes to their counterparts in the four CBAs, with their primary role being assessing the needs of patients upon discharge and connecting them to DMEPOS suppliers. In most cases, patients are given a list of suppliers within their geographic area who accept Medicare referrals, and are then given an opportunity to choose. Unless the patient has prior experience with a supplier, they often defer to the referral agent for advice. Timeliness of delivery and quality of customer service are, as heard everywhere else, the two most important factors when determining a list of “preferred” providers. Referral agents in all three comparison areas described the DMEPOS marketplace as “very competitive,” with plenty of suppliers, resulting in adequate access to products and services and good quality of care to beneficiaries overall. One key informant in Tampa explained this by saying “it’s so competitive that they’re [suppliers] always tripping over each other trying to impress the patient . . . they go out of their way to make sure they provide a good service.” As with other areas, the majority of suppliers are small, independent companies, with a few larger, national – and, in some cases, dominant – entities.

##### Suppliers

Suppliers echoed many of the sentiments shared by referral agents. Most referrals come directly from doctors’ offices, hospitals and home health agencies, with additional business through word of mouth; very little is a result of retail or “walk-in” traffic. Direct marketing within the health care sector, along with positive references from existing and past customers, are the principal means of attracting

referrals. Overall, suppliers are satisfied with the referral process and feel that they have established good working relationships with referral agents in their respective geographic areas.

Interviewees agreed that there are “plenty” – some went so far as to say “too many” – suppliers to meet the demands for DMEPOS in these three metropolitan areas. One supplier in Houston noted that this can be an advantage, particularly for smaller companies, saying that “I have a . . . network of good DME suppliers that I can refer to if I can’t do a job.” As heard from referral agents, competition is intense and, as one informant in Tampa emphasized, suppliers must “earn” business, no matter what their size or share of the market. A mid-size supplier in San Diego explained that, because suppliers are “on a level playing field in terms of price . . . it comes down to customer service.” Others agreed, indicating that timeliness and responsiveness to patients’ needs are key factors in building a referral base and developing a positive reputation among beneficiaries.

### **Other Stakeholders**

Beneficiary advocacy groups indicated that their elderly clients are often confused by various aspects of their health care, including insurance coverage and the DMEPOS they receive. As a result, these service groups often intervene to inform and educate beneficiaries and, in some instances, refer them to appropriate service providers. A representative from Houston explained that fraud in the DMEPOS industry, past and present, is of particular concern for this “vulnerable” population; she makes it a practice to check with the Better Business Bureau before making a referral to a supplier. Another informant in California asserted that suppliers, and more specifically their advertising campaigns, “prey on seniors” and “care about making a sale, not their (beneficiaries’) needs.” However, one interviewee from Tampa noted recent improvement in customer service, and wondered if this change in behavior might be the result of the impending bidding program and increased competition.

#### **4.1.2. Expectations of Market Participants Regarding the Impact of Competitive Bidding on Referral Processes and the Functioning of the DMEPOS Market**

Suppliers in all three areas expect that Medicare competitive bidding will reduce the number of available suppliers, although they disagree as to whether this will affect product quality. One supplier in Tampa predicts that manufacturers will respond by building products “to meet the price range set through competitive bidding and quality will decrease.” The smallest independent suppliers that are most dependent on Medicare fear they will be early casualties, because they will be unable to offer competitive bids without sufficient volume or, even if they are successful, to recoup the money required to maintain accreditation. Another informant in Tampa reported that suppliers in the area are already “bleeding out” from the 10% price cut imposed in 2008, and will eventually go out of business. Several others suggested that while competitive bidding will help weed out some fraudulent suppliers, other activities could be equally effective at reducing fraud (e.g., inspecting suppliers, passing more-stringent quality standards) without such an administratively expensive and burdensome program. Suppliers also raised concerns that when there are fewer suppliers, patients will no longer get necessary service and education.

Referral agents and other stakeholders in comparison areas were not very knowledgeable about competitive bidding for DMEPOS overall. One informant from San Diego, admittedly the exception to this rule, stated that he “read the writing on the wall a few years ago,” and had diversified his business in order to survive. He confirmed that most others are “waiting to see what’s going to happen” as a result of the Round One rebid, and one small supplier in Houston said that his company is “pretending it is not going to happen.”

## 5. Baseline Cross-Site Themes

The purpose of these baseline case studies in CBA and comparison areas is to understand the environment in which competitive bidding is taking place, and the concerns of key stakeholders at the start of the competitive bidding program. Many of the issues participants raised warrant careful monitoring to observe, for example, whether access to DMEPOS products and services is impaired in rural areas, whether beneficiaries experience inferior products and inadequate service, and whether small suppliers are able to compete effectively and thrive in the program.

The following sections summarize the themes that will be revisited in future case studies, beneficiary surveys, and other evaluation data collection and analysis.

### 5.1. Current Market Functioning and Competition

#### Current Market Capacity and Adequacy

Referral agents, suppliers and key stakeholders in each market share the view that the current number of DMEPOS suppliers in CBAs and comparison areas is sufficient to meet most existing needs of Medicare beneficiaries. For products prescribed most often (e.g., wheelchairs, walkers, oxygen) the number of suppliers appears to be more than adequate in all sites. Some participants in each site also identified particular gaps in access for products that are not included in the Round 1 Rebid, such as specialized or complex equipment for home patients.

Participants in Riverside consistently cited concerns related to geography. This CBA is extremely large with a mix of sprawling urban centers (Riverside, San Bernardino) and rural areas, some of which are fairly remote (the most rural and low density portions of this CBA were exempted from competitive bidding). Heavy traffic around the larger urban centers, along with weather and road conditions in the often sparsely populated desert and mountain areas, pose noteworthy problems, and few vendors serve the most rural areas. Participants in Dallas also alluded to the large size of that CBA, but it does not appear that this poses as severe a challenge to suppliers or beneficiaries in that market.

The nature of the DMEPOS market continues to change in response to managed care policies, Medicaid rules and state Medicaid reform initiatives, and other payment issues. Managed care plans typically limit the suppliers that their members and contracted health providers can use, Medicaid sometimes does the same, and the Medicare competitive bidding program will add further complexity, especially for dual-eligible patients.

#### Benefits of Competition

Case study participants, including suppliers, believe that intense competition has had a very positive effect on service access and quality. The four CBAs and three comparison site areas each have substantial DMEPOS capacity, and suppliers compete on timely equipment delivery, product quality, patient education, skilled technical and clinical staff (e.g., respiratory and physical therapists), after-hours delivery and maintenance, and responsiveness to complaints.

Referral agents are able to choose among many large and small suppliers, and they maintain lists of those they prefer. They favor suppliers that provide generally outstanding service, and many find it helpful to work with vendors who accept all payers so that there is less concern with matching the patient with an authorized supplier. Other referral agents expressed a preference for suppliers that can meet all of a patient's needs; this greatly reduces the workload involved in coordinating multiple suppliers, as well as confusion for beneficiaries. Hospital discharge planners value the ability to have a piece of equipment delivered to the hospital before a patient is discharged home, or immediately thereafter, without an interruption in service. This ensures smooth transitions/discharges, which is a very important goal. Referral agents also prefer suppliers who have highly trained staff (not just drivers) to set up equipment in patient homes. Some suppliers excel at patient education and will return as often as necessary to make sure that a patient is using the equipment correctly.

Referral agents see these features and activities as benefits of a highly competitive market. Suppliers who participated in focus groups, almost all of whom are local and independent companies, agree that competition is healthy, and many say that they welcome it. Suppliers in all CBAs define their companies as part of an industry that is based on service, which they anticipate may be undermined by dramatically lower Medicare reimbursement.

Suppliers have traditionally been referral agents' main source of information about the competitive bidding program and other DMEPOS matters. Suppliers regularly visit referral agents to provide updates on new equipment, and some conduct brief seminars that may provide continuing education credits for referral agents and other staff.

## **5.2. Anticipated Effects of Medicare Competitive Bidding**

Referral agents, suppliers, and senior service organizations voiced many strong concerns about the potential impact of Medicare competitive bidding for DMEPOS. They worry that the program will lead to a significant decrease in the number of suppliers available to serve Medicare beneficiaries, reduced competition within the industry, and many other negative consequences. In discussing these concerns, participants focused almost exclusively on their perception that competitive bidding would have detrimental effects. Although they acknowledge that competitive bidding may reduce expenditures to the Medicare program and that it may further decrease fraud in the DME industry, participants believe that these benefits will be strongly outweighed by other costs and consequences.

### **Timeliness, Service Quality, and Health Outcomes**

All participants predict that current standards for timeliness, quality, and other service features will suffer greatly when competitive bidding is implemented. They are convinced that lower payment rates and fewer suppliers to serve beneficiaries will affect service in unacceptable ways. For example, they predict that response times will be slower, suppliers will be unable to afford skilled technicians/clinicians who can set up equipment and train patients, there will be fewer choices of products, and product quality will diminish as less expensive products replace those currently in use. Furthermore, participants suggest that competition has been a positive force in driving the industry to be very responsive to both patients and referral agents, and that competition will diminish with competitive bidding.

The consensus among case study participants is that these consequences are unavoidable, as competitive bidding proceeds. They elaborated on these and additional related concerns:

- Referral agents expect that suppliers may become overextended when there are fewer of them and, therefore, suppliers may be less able to deliver equipment when it is needed. This may result in longer hospital stays. Many participants feel that, with fewer approved Medicare suppliers, there will be less competition. With less competition, they foresee that timeliness will suffer. More importantly, they believe, timeliness suffers when the supplier is not a locally-based business with strong community ties and longstanding relationships with beneficiaries and referral agents. There is a strong and widely held belief that competitive bidding will put smaller vendors out of business.
- Study participants fear a worst-case scenario in which suppliers no longer send highly trained technicians to set up equipment in patient homes and teach patients how to use it. Patients who do not use their equipment correctly may deteriorate, and these negative health consequences could lead to hospital readmissions, more nursing home admissions, and more complex and expensive home care, with attendant costs.
- Similarly, suppliers have concerns that they may no longer be able to offer the complex equipment and careful fittings some patients require, reducing quality of care and patient satisfaction. One large supplier suggests that companies will “cherry pick,” meaning that they will stop providing DMEPOS in categories that require high levels of costly service.
- Suppliers anticipate that they will be forced to carry equipment that is less expensive in order to stay in business, and they equate lower price with lower quality.

### **Role of Referral Agents**

Referral agents characterize their jobs as very labor-intensive, and they believe the referral process will become more complicated and time consuming under competitive bidding. Referral agents expect to be working with multiple suppliers to meet some patients’ needs, each holding Medicare contracts for different products. Referral agents who are also health care providers, especially home health nurses, say they may need to shoulder more responsibility for dealing with patient problems and needs if services performed by suppliers’ clinical staff, like patient education, are no longer provided.

Many managed care organizations in these communities already use lists of payer-authorized suppliers, and some states are moving in this direction for Medicaid as well. With the advent of Medicare DMEPOS competitive bidding, referral agents raised concerns about being able to do “one-stop shopping” on behalf of these clients, that is, finding a supplier authorized by both Medicare and Medicaid, who can meet all of a patient’s DME needs.

### **Reducing Fraud**

During research conducted in 2007, a number of suppliers believed that the main objective of the Medicare competitive bidding program was to reduce fraud in the DME industry. Although participants in 2010 recognized that this remains an objective, they unanimously view cost savings as the predominant goal of competitive bidding. Suppliers perceive that better monitoring efforts and, more particularly, accreditation and state licensing requirements have greatly reduced fraud over the past few years, and they do not view the competitive bidding program as an effective way to reduce

fraud. A few participants suggested that competitive bidding may open the door to increased fraud, as suppliers enter some markets for the first time.

### **Winners and Losers (Suppliers)**

Many DMEPOS suppliers are convinced that they will not be able to sustain current levels of service at the prices they bid. Reductions in reimbursement rates along with price increases by manufacturers, an “unreasonable audit burden,” and “excessive paperwork” have “cut prices to the bone” and eliminated the margin on many products. They predict that the supplier market will change dramatically, to the detriment of all, with fewer suppliers available to serve beneficiaries’ needs, because many small, local companies -- including independent, family-owned businesses -- will be forced to close or will be subsumed by larger companies. They anticipate that market change of that nature will have far-reaching negative effects, including effects on local unemployment rates, local and regional economies, and beneficiary access to DMEPOS.

Suppliers in our focus groups reported that they had no choice but to bid, because they are dependent on Medicare. Suppliers found it hard to estimate operating costs and staffing needs in their bids, or estimate profits, without any way to anticipate volume. Most suppliers made their best estimates and then bid lower, sometimes substantially lower, in order to improve their chances. Some suppliers tried to simplify things for themselves by cutting a fixed percentage (e.g., 5 or 10%) off their best price. All expect that small suppliers may be less likely to win Medicare contracts, or will bid so low that they cannot remain in business even if they are awarded contracts. Larger companies, especially those affiliated with chains, can take advantage of bulk purchasing, centralized billing and distribution, shared resources, and other economies of scale that increase their chances of winning a contract and succeeding at the contracted price. Despite these apparent advantages, one national supplier said that his company has already laid-off workers and centralized more services in anticipation of competitive bidding.

We learned that consultants assisted some suppliers in Riverside, and this may have occurred in other CBAs. It was reported that consultants may suggest the same prices for multiple bidding suppliers in a CBA, thereby influencing the bidding process.

Many suppliers in our groups cling to the hope that Congress will bow to intense pressure being exerted by the industry and suspend competitive bidding before it begins in January, 2011. Others are certain that competitive bidding will proceed, but that the consequences will so severely undermine the DMEPOS market, service delivery, and the health of beneficiaries, that it will not continue.

### **Program Awareness and Knowledge**

Suppliers have followed developments in the Medicare competitive bidding program, and their trade organizations have closely monitored the details and have attempted to keep their members well informed. Nonetheless, focus groups revealed that many suppliers do not fully understand the methods by which Medicare will weigh price against capacity, quality, and other criteria in evaluating bids. Many believe that it will all come down to price. Focus groups were held in three of the four CBAs immediately after winning prices had been announced. Many suppliers did not understand what would happen next, whether they should automatically assume that they will win a contract if they bid the prices that had been accepted, and when they will be officially notified.

Referral agents appear to be much more aware of competitive bidding than were their counterparts in 2007. Some referral agents know a bit more of the details, mainly because suppliers have discussed the program with them. Some institutions, particularly the hospitals, have provided information to their staffs.

Of those who elected to participate in this study, beneficiary organizations, especially the SHIPs, have a good understanding of the program features that are most relevant and important for their constituents to know. These agencies are planning education and outreach activities, developing strategies to address beneficiary concerns and alleviate confusion, and anticipating the particular problems likely to confront specific populations (e.g., Hispanic/Latino). These informants are also aware that CMS has scheduled training sessions for agency staff and volunteers.<sup>6</sup>

Focus groups and interviews provided insights into gaps in knowledge about the program, and areas of misunderstanding that have persisted since 2007:

- Referral agents are not sure when and how they will learn which suppliers have been awarded Medicare contracts for particular products. As in 2007, they claim that they have received little communication from CMS. There is a wide range of engagement, and the degree to which referral agents follow developments on the CMS web site and list-serve. The list-serve may be a useful mechanism for informing some referral agents, but other avenues will be needed to reach the majority (whether concerning DMEPOS competitive bidding or other Medicare matters).
- Very few suppliers or referral agents seem to be aware of the special provisions for suppliers in rural and low-density geographic areas. While a few mentioned the program provisions that encourage participation of small suppliers, many voiced concern about the ability of small suppliers to compete effectively.
- Referral agents and suppliers appear not to have focused on the fact that beneficiaries' out-of-pocket costs could be reduced by the competitive bidding program. This potential benefit was mentioned only occasionally in focus groups and interviews.
- A fundamental misunderstanding of the origins of, and responsibility for, the DMEPOS competitive bidding program persists. Some study participants assume that CMS initiated and is responsible for all aspects of program design.

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<sup>6</sup> CMS has an active outreach and education campaign underway, to help prepare for the transition to the newly contracted suppliers, and assist beneficiaries, referral agents and others during the transition. See CMS details at: [https://www.cms.gov/CMSLeadership/12\\_Office\\_OEABS.asp](https://www.cms.gov/CMSLeadership/12_Office_OEABS.asp) and <http://www.cmspulse.org/oea.html>