Report to Congress

Evaluation of the National Competitive Bidding Program For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

U. S. Department of Health and Human Services

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EXECUTIVE SUMMARY

Introduction

Section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173) established a competitive bidding process for Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as a permanent part of the Medicare program. The law and subsequent amendments (see section 154, Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L. 110-275)) added section 1847(d) to the Social Security Act, which requires the Secretary to submit a report to Congress on the competitive bidding program. This report responds to the legislative reporting requirement; it provides information on the outcome of the bidding process, perspectives of stakeholders during the pre-implementation phase of the program (mid-year 2010), and estimates of program savings in the first year of program operations (2011) in the nine competitive bidding areas (CBAs) operating during the program's first year. Because payment operations under the new program began on January 1, 2011, it is premature to evaluate impacts of the new program other than the estimated Medicare savings. The information gathered to date will serve as a foundation for comparison with data to be collected later as the program continues.

Background

MIPPA specifies the nine metropolitan areas in which the Centers for Medicare & Medicaid Services (CMS) must launch the first phase of national competitive bidding. Approximately 2.3 million Original Medicare beneficiaries[1] (about 7.1 percent of Original Medicare Part B enrollment nationally) are potentially affected by the first phase of the new program, though a smaller number--about one in three--uses DMEPOS in a given year. The nine areas are:

- Charlotte-Gastonia-Concord (North Carolina and South Carolina)
- Cincinnati-Middletown (Ohio, Kentucky, and Indiana)
- Cleveland-Elyria-Mentor (Ohio)
- Dallas-Fort Worth-Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami-Fort Lauderdale-Pompano Beach (Florida)
- Orlando (Florida)
- Pittsburgh (Pennsylvania)
- Riverside-San Bernardino-Ontario (California)

The MIPPA also specified nine DMEPOS product categories for the first round of bidding:

- Oxygen Supplies and Equipment
- Standard Power Wheelchairs, Scooters, and Related Accessories
- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2[2])
- Mail-Order Replacement Diabetic Supplies
- Enteral Nutrients, Equipment, and Supplies
- Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RADs), and Related Supplies and Accessories
- Hospital Beds and Related Accessories
- Walkers and Related Accessories
- Support Surfaces (Group 2[3] mattresses and overlays) in Miami only[4]

A 60-day bidding period began on October 21, 2009. Across the 73 separate competitions, CMS received a total of 6,215 bids from 1,011 suppliers. Bidding suppliers had to be accredited and licensed to perform the services identified in the request for bids, and they had to meet financial standards in order to be eligible to win a contract. Bid prices had to be lower than the statutory fee schedule price. To guard against improperly low bids, CMS requested and evaluated additional information from suppliers before deciding whether to accept an usually low bid. Each supplier offering a bid in a product category had to specify a bid price for every item in the category. A product category composite bid was created based on a supplier's bid prices and beneficiary utilization data. The composite bid was calculated by multiplying the weight of each item by the supplier's bid price for each item, where the weight of each item was based on the national beneficiary utilization data for the individual item compared to the other items within that product category.

In each CBA, CMS separately arrayed the composite bids for each product category from lowest to highest. Each qualified bid was assigned a capacity that CMS determined was a reasonable unit total that the supplier could be expected to provide each year. Proceeding from the lowest qualified bid, bids were accepted into the program until a pre-determined total demand target (i.e., projected total demand) was met by all selectees collectively. Item bid prices from the set of bids selected in this manner determined the new DMEPOS single payment amounts in the CBA. Specifically, for each item in the product category, the median bid price from the list of winning bids was set as the single payment amount. Because the law specified that small suppliers must be protected, CMS checked each competition's results to ensure that at least 30 percent of the winning bids came from small suppliers. If more small suppliers were needed to reach the 30 percent small-supplier target, additional small suppliers were offered contracts, but such additions to the list of suppliers did not change the competitive bidding program single payment amount.

Results of Competitive Bidding: Suppliers

CMS announced the final set of contract suppliers on November 3, 2010. The agency awarded a total of 1,217 contracts to 356 suppliers. Because a supplier could compete in multiple product categories and areas, the number of contracts awarded was larger than the number of suppliers that won. In four areas (Charlotte, Dallas, Miami, and Orlando), oxygen supplies and equipment represented the category with the highest number of contracts awarded. In four other areas (Cincinnati, Cleveland, Kansas City, and Pittsburgh), enteral nutrients was the category with the highest number of contracts awarded. In Riverside, the category with the greatest number of contract awards was standard power wheelchairs. Although oxygen supplies and equipment generated the lowest number of bids of any product category, the category produced the highest number of contracts awarded in total (259). In contrast, for mail-order diabetic supplies, a very small number of contracts was awarded (107) relative to the number of bids (1,454). This is perhaps due to the large scale of order fulfillment operations that is possible for a single firm doing mail order business and the large variety of sources that participate in the mail order diabetic supplies market. Among all CBAs, Miami, with the largest Part B enrollment, had the highest number of contract awards in each product category, with the exception of standard power wheelchairs.

Suppliers that did not submit bids or did not receive a contract in response to a bid could elect to continue providing rented oxygen or other rental DME to customers who were renting these items when the program began (which is referred to as being grandfathered). (Grandfathering does not apply to mail order diabetic supplies, which are not rental items, or to enteral nutrition, which is not DME.) Approximately 4,600 suppliers notified CMS that they planned to be grandfathered.

Results of Competitive Bidding: Prices

The bidding process resulted in a generally large reduction in Medicare prices. Across the product categories, the average price reduction ranged from 10.5 percent for complex power wheelchairs to 41.2 percent for support surfaces, a category that includes such items as pressure-reducing mattresses. The following summaries of price reductions are descriptive of DME item price changes and do not represent savings, a topic that we treat in a later section.

Category-specific price reductions varied. Support surfaces had the highest reduction at 41 percent; this category was put up for bidding in the Miami area only. Relatively large price reductions also occurred in the category for continuous positive airway pressure (CPAP) machines (34 percent lower prices on average across the 9 CBAs) and walkers (34 percent average reduction). The smallest price reduction was for the complex power wheelchairs category, where prices declined an average of 11 percent; this category had the smallest number of bids offered across the CBAs, a fact which may help explain the smaller reduction in comparison to reductions in other categories. In addition to competition-related factors such as the number of bidders, profit-margin differences, which might be partly related to the size of fee schedule reductions in recent years, are likely a cause of the product-related variation in the price reductions. For example, oxygen and power wheelchairs each experienced relatively large fee schedule reductions in recent years.

There was less variation in the reductions across geographic areas, with a 13 percentage point difference in the average price reduction between the area with the smallest reductions (Kansas City) and the area with the largest reductions (Miami). The variation in average price reductions across the areas is not explainable by differences in the pre-existing statutory fee schedules, as these schedules had a virtually uniform average price.

The pattern of price reductions suggests that the particulars of both the local markets and characteristics of the product categories themselves contributed to the overall results of competitive bidding in the Round One Rebid.[5]

Results of Competitive Bidding: Early Program Monitoring

CMS has in place an array of administrative and analytic activities to monitor the implementation and performance of the competitive bidding program. CMS' various program monitoring activities include routine consumer satisfaction surveys, a formal complaint tracking and resolution process, quarterly supplier reporting of makes and models of equipment/supplies provided to beneficiaries, secret shopping to evaluate the performance of contract suppliers, and local-level monitoring and outreach by CMS' regional office staff and CBIC ombudsmen stationed among the CBAs. In addition, the national Competitive Acquisition Ombudsman responds to inquiries and complaints from suppliers and individuals relating to the application of the competitive bidding program.

Program monitoring activities also include ongoing analysis of two important sources of data: the National Claims History and the 1-800-MEDICARE call center operations. Analysis of the National Claims History consists of real-time tracking of claims volumes and of health outcomes as measured by utilization rates and mortality for three types of populations (e.g., users of individual product categories) in the CBAs and comparison areas. In addition to monitoring health impacts and utilization trends, the data are used to monitor beneficiary access, address aberrancies in services, and target potential fraud and abuse. On June 30, 2011, CMS posted initial results of the claims-based health outcome monitoring on its website (see http://www.cms.gov/DMEPOSCompetitiveBid/01A3_Monitoring.asp#TopOfPage). Results covered the first three months of the new program. The data showed no indications of changes in beneficiary health outcomes resulting from the competitive bidding program. Updated analyses will be posted monthly.

Results from the first 25 weeks of 1-800-MEDICARE call center tracking suggested a downtrend in inquiry volumes that is likely indicative of decreasing needs for information about the new program as the CBAs move through the early, transition months of competitive bidding. Inquiries relating to assistance in acquiring equipment and supplies were dominated by needs for assistance with diabetic supplies. This is not surprising, since diabetes prevalence in the Medicare population is high, and needs for diabetic supplies are regular and ongoing, whereas needs for most categories of equipment are generally occasional. A very small number of inquiries—116—have been classified as complaints and referred to the CBIC or CMS officials. Overall indications from the call center data are that beneficiaries are experiencing a relatively smooth transition to competitive bidding in the Round One Rebid CBAs.

Baseline Perspectives on DMEPOS Markets

The design for the competitive bidding program evaluation project includes comparative case studies in four Round One Rebid CBAs (Dallas, Orlando, Riverside, and Cleveland) and three areas not selected for the Round One Rebid (Houston, Tampa and San Diego). The first phase of data collection for the case studies took place in Summer 2010, to establish a baseline of qualitative information before the contract awards were announced. The purpose of collecting information at baseline was to understand the context in which competitive bidding was taking place: the competitive markets for DMEPOS; the relationships between suppliers and so-called referral agents—usually clinical personnel who refer beneficiaries for DMEPOS services and often assist them throughout the process of procuring the equipment; the level of awareness and knowledge about the competitive bidding program; and the anticipated effects of the program. For purposes of comparison, information was collected in the three non-CBA areas selected for study. Perspectives were sought from a variety of stakeholders, such as suppliers, supplier representatives, beneficiary representatives, and referral agents.

The stakeholders in each market shared the view that the number of DMEPOS suppliers in CBAs and comparison areas in 2010 was at least sufficient or, if not, more than adequate to meet Medicare's needs. Referral agents reported that suppliers compete aggressively, primarily in terms of delivery timeliness, product reliability, beneficiary training in equipment use, and fast response time for repair needs. Under a uniform fee schedule, of course, suppliers do not compete on price.

In mid-2010—before CMS began its intensive public education campaign in the nine CBAs—the case study participants exhibited certain information needs and misconceptions about the new program. For example, few suppliers or referral agents understood that rural areas were excluded from the program launch. Few recognized the potential benefits of the program in terms of out-of-pocket savings for beneficiaries.

The case studies revealed a widespread sense of concern about potential adverse outcomes under DMEPOS competitive bidding. These concerns pertained primarily to service quality, product selection, and potential disruptions in access during the transition to a new program.

The evaluation team's baseline case studies will be followed up with additional case study activities in mid-2011, focusing on experiences during the transition. In mid-2012, a final wave of case-study data collection will occur.

Estimates of Medicare Savings

For this report, we estimated annual savings in the nine CBAs in the first year of the program, based on analysis of the Medicare National Claims History. Our savings estimates take into account only direct effects on DMEPOS outlays due to item price reductions. We do not take into account savings from reduction in fraud and abuse, which are difficult to quantify.

Two types of estimates were prepared. The first one estimates savings in allowed charges for Medicare and its beneficiaries combined (total savings), and the second estimates savings in the government's payments to suppliers (subsequently referred to in this report as "program payments"). The claims data used to measure volume and prices in the absence of competitive bidding are from 2009, so results should be considered estimates of how much would have been saved if competitive bidding prices had been in effect in 2009. The use of claims from 2009 would only be a serious limitation of this approach if volume were to change substantially as a result of competitive bidding; the statutory statewide fee schedules upon which the savings are based have changed negligibly since 2009. When the evaluation project's assembly of the claims history is completed in two years, the study will address the question of program-associated volume changes in the final estimates of savings. Therefore, this report's estimate of savings is provisional.

In 2009, Medicare allowed charges for all the product categories in the Round One Rebid CBAs totaled $381.27 million, with Medicare responsible for $298.83 million and beneficiaries responsible for the remainder through their payment of deductibles and copayments.[6] Oxygen equipment and services accounted for 44 percent of total allowed charges, followed by standard power wheelchairs at 17 percent, mail order diabetic supplies at 14 percent, enteral nutrition products at 12 percent, CPAP at 5 percent, and hospital beds at 5 percent. The remaining three categories, complex power wheelchairs, walkers, and support surfaces, accounted for approximately 1 percent or less of total allowed charges.

Overall, across all product categories and CBAs, we estimate the average percentage savings from competitive bidding to be 35 percent, based on either Medicare allowed charges or program payments.[7] Overall annual savings are estimated to be $134.6 million based on allowed charges and $105.3 million based on program payments, which means that beneficiaries in the nine CBAs would save the difference between these two amounts, or approximately $30 million. The following overview of the results focuses on allowed charges, because results for program payments are basically the same.

Across the nine product categories, savings percentages for allowed charges range from 18 percent to 55 percent. Savings in allowed charges are the greatest for mail order diabetic supplies (55 percent) and support surfaces (49 percent), followed by CPAP (38 percent), hospital beds (36 percent), walkers (35 percent), oxygen (32 percent), enteral nutrition (also 32 percent), and standard power wheelchairs (29 percent). Savings for complex power wheelchairs are the smallest, at 18 percent; this category also had the lowest average percentage reduction in prices relative to the statutory fee schedule amounts.

The oxygen product category accounts for $53.7 million of the estimated savings in total allowed charges, or 40 percent of the entire $134.6 million in estimated savings. Mail order diabetic supplies account for another 21 percent of the total savings in allowed charges, followed by

standard power wheelchairs (14 percent) and enteral nutrition (11 percent). The remaining five product categories account for 14 percent of the savings.

Across the CBAs, estimated savings percentages range between 32 percent (Riverside) and 40 percent (Cleveland). The savings percents are relatively high in the northernmost CBAs (Cincinnati, Cleveland, and Pittsburgh).

Examination of the individual DMEPOS items in terms of the savings realized in the Round One Rebid indicates that the items with the three largest allowed charges together account for $89.7 million saved; the items are oxygen concentrators, blood glucose test strips, and semi-electric hospital beds. The top 24 largest-saving items (across all Round One Rebid CBAs) collectively represent $130.7 million in savings. All product categories, with the exception of complex power wheelchairs, were represented in this top-saving list.

Conclusions

The information in this Report to Congress suggests that savings from the DMEPOS competitive bidding program in its first year, 2011, will be substantial. The results from bidding in the nine Round One Rebid CBAs, across all nine product categories, are estimated to yield savings of $134.6 million, or 35 percent, in allowed charges. Savings accruing to the Medicare program are estimated at $105.3 million, and savings accruing to beneficiaries are approximately $30 million. More precise estimates will be made after data on actual realized volume in the CBAs are analyzed at the end of next year.

CMS continues to collect information on the outcomes of the competitive bidding program in the Round One Rebid CBAs. More results, beyond those available for this report, are under study. Surveys of beneficiaries, continued case study activities, and analysis of the National Claims History under competitive bidding are some of the most important data collection methods we will utilize. These materials will be analyzed to identify impacts of the new program on quality of services, access to services, beneficiaries' satisfaction with their suppliers, and expenditures. A final report of the entire research effort is expected to be released in 2013.

1. Background and Scope of this Report

Section 302 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173) established a competitive bidding process for Part B durable medical equipment, enteral nutrition, and off-the-shelf orthotics as a permanent part of the Medicare program. Section 302 also required a report to Congress addressing the impacts of the program, including savings, reductions in cost-sharing, access to and quality of services, and beneficiary satisfaction. Effective June 30, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (P.L. 110-275) temporarily suspended the competitive bidding program,[8] made several revisions to it, and changed the original date for the report from July 1, 2009, to July 1, 2011. This report fulfills the impact study requirement

In 2008, Medicare Part B paid approximately $8.3 billion on behalf of 10.2 million beneficiaries for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Of this total, approximately $2.3 billion was paid for oxygen and related supplies on behalf of 1.6 million beneficiaries. DMEPOS program payments accounted for slightly more than 6 percent of all Part B payments.[9] Approximately 32 percent of Medicare's fee-for-service beneficiaries received one or more DMEPOS items in 2009.

Studies of the Medicare DMEPOS benefit have found that its prices are excessive and that the program is vulnerable to abuse.[10] The competitive bidding program is one of several changes in recent years that address the cost and abuse of the DMEPOS benefit.[11] Reductions in program costs as a result of competitive bidding could be substantial, as suggested by results from DMEPOS competitive bidding demonstrations in two metropolitan areas during 1999-2002.[12] According to the Government Accountability Office (GAO), competitive bidding could also help to reduce Medicare's vulnerability to abuse because the bidding process requires government scrutiny of firm-related information such as documents pertaining to financial condition, licensure, and accreditation.[13]

CMS began rulemaking for the competitive bidding program in 2006.[14] The final regulation, issued in 2007,[15] detailed program design decisions in many areas, proceeding from the basic requirements laid out by Congress for phasing in the program, defining competitive bidding areas (CBAs), selecting items to put up for bidding, protecting beneficiaries from access disruptions and quality deterioration, and safeguarding small business participation. Shortly after payment operations under the new program began in mid-2008, the competitive bidding contracts awarded in the first round of bidding were terminated effective June 30, 2008, as a result of the MIPPA mandates revising and delaying the program. A new round of bidding, known as the Round One Rebid, began in October, 2009, in nine of the original 10 areas, involving nine of the original ten product categories selected for the 2007 round. Following completion of the bid evaluation process, CMS began contracting with winning suppliers and executed contracts in the fall of 2010.

The next phase of the program is required to begin in 2011. The Patient Protection and Affordable Care Act of 2010 expanded the number of Metropolitan Statistical Areas (MSAs) for the 2011 phase from 70 to 91 areas.

This report provides information on the outcome of the bidding process, early results from CMS's program monitoring activities, perspectives of stakeholders during the pre-implementation phase of the program (mid-year 2010), and estimates of program savings in the first year of program operations (2011) in the 9 CBAs. Because payment operations under the new DMEPOS contracts began January 1, 2011, it is premature to evaluate impacts of the new program other than early indicators of transition experience and likely Medicare savings. To collect much of the information for this report, CMS contracted with Abt Associates of Cambridge, Massachusetts.[16] Sources of information for this report include statistical information from the bidding process; selected program monitoring data; the new DMEPOS prices that resulted from the bidding process; discussions and interviews with government officials, stakeholders, and other observers, as well as focus groups with suppliers and health care personnel; and fact-finding using a variety of publicly available information. Much of the information gathered to date will serve as a foundation for comparison with data to be collected later as the program unfolds.[17]

This report presents the study findings to date in five sections. First, we describe how Medicare conducted the competition, and the contract awards and price changes that resulted (Section 2). Second, we review selected early results from CMS' program monitoring activities. We then turn to CMS' activities in preparing beneficiaries and other stakeholders for the new environment, in which only contract suppliers are available to beneficiaries who begin using certain medical equipment (Section 4). Next, we report on the perspectives of interview subjects and focus group members in the summer of 2010, in order to establish a baseline for later comparisons (Section 5). Finally, we present estimates of program savings expected in the first year of operations (Section 6).

2. Conduct and Results of the Bidding Phase

The MMA specified that CMS must launch the first phase of national competitive bidding in 10 MSAs and that these areas should be among the largest in terms of total population. In 2007, using a selection methodology finalized in regulations, CMS identified 10 areas for Round One, opting to exclude the three largest metropolitan areas for the first round (e.g., New York City) as a precaution that would allow for building experience with the new program.[18] In MIPPA, Congress confirmed CMS' selection of areas, but eliminated Puerto Rico from the original set, leaving nine areas for the Round One Rebid. Table 1 shows the Round One Rebid CBAs and each area's Part B-enrolled fee-for-service residents in 2009. Approximately 2.3 million Original Medicare beneficiaries[19] (about 7.1 percent of Original Medicare Part B enrollment nationally) are potentially affected by the first phase of the new program, though a smaller number--about one in three--uses DMEPOS in a given year.

Table 1: Round One Rebid Competitive Bidding Areas and Medicare Part B Fee-for Service Enrollment: 2009

Competitive Bidding Area	Part B enrollment
Charlotte-Gastonia-Concord (North Carolina and South Carolina)	169,402
Cincinnati-Middletown (Ohio, Kentucky, and Indiana)	192,103
Cleveland-Elyria-Mentor (Ohio)	227,982
Dallas-Fort Worth-Arlington (Texas)	443,328
Kansas City (Missouri and Kansas)	176,603
Miami-Fort Lauderdale-Pompano Beach (Florida)	447,678
Orlando (Florida)	218,762
Pittsburgh (Pennsylvania)	157,176
Riverside-San Bernardino-Ontario (California)	220,420
TOTAL	2,253,454

MIPPA also specified the nine DMEPOS product categories for the Round One Rebid[20]:

- Oxygen Supplies and Equipment
- Standard Power Wheelchairs, Scooters, and Related Accessories
- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2[21])
- Mail-Order Replacement Diabetic Supplies
- Enteral Nutrients, Equipment, and Supplies
- Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RADs), and Related Supplies and Accessories
- Hospital Beds and Related Accessories
- Walkers and Related Accessories
- Support Surfaces (Group 2[22] mattresses and overlays) in Miami only[23]

The Bid Review Procedure

CMS managed the bidding process with the assistance of Palmetto Government Benefits Administrators (PGBA) of South Carolina, which served as the Competitive Bidding Implementation Contractor (CBIC). An on-line bidding system was mandatory for suppliers to use in submitting much of the required information, including the bid prices. A 60-day bidding period began on October 21, 2009. Across the 73 separate competitions, CMS received a total of 6,215 bids from 1,011 suppliers.

Bid documentation had to include names of the models of equipment that the supplier intended to offer beneficiaries.[24] Bidding suppliers had to be accredited and licensed to perform the services included in the request for bids, and they had to meet financial standards

in order to be eligible to win a contract. Certain financial and non-financial documents had to be submitted in hard copy (for example, income statements, balance sheets, credit reports and scores, tax return extracts, subcontractor agreements, and other documentation). Bidders who sent their financial documents before an early document submission deadline were notified in writing if any financial documents were missing and, after receiving notification, they had 10 business days to submit the missing documents.[25]

Bid prices were required to be lower than the statutory fee schedule price.[26] All bids were screened and evaluated to ensure they were bona fide. This process was completed after all other eligibility screenings and before CMS identified the single payment amounts. To ensure that bids were bona fide, CMS screened the bids using statistical dispersion measures. Suppliers that submitted bids identified as extremely low in relation to other bids were asked to submit additional information (such as manufacturers' invoices) to prove that the item could actually be furnished at the bid price. If a bidder did not prove that it could furnish an item at the bid price, the bidder was eliminated from competition for the given product category and CBA.

To evaluate financial viability--part of the assessment of the supplier's ability to help meet expected demand in the CBA-- the CBIC calculated standard accounting ratios using the financial statements and tax return. The financial ratios and credit score were summarized in a score for each bidder. The CBIC then compared the score to a threshold to determine whether a supplier met the minimum financial standards to continue in the bid review process.[27]

As part of their bid, suppliers had to declare their recent volume in the CBA and the volume they anticipated they could provide under the new program. CMS evaluated the anticipated capacity if it exceeded the supplier's actual capacity, which was verified by CMS in the National Claims History. CMS took into consideration not only recent actual capacity but also financial documentation and the financial score, credit scores, and the credibility of the supplier's expansion plans. For purposes of arriving at the list of winning bids, CMS capped anticipated capacity for any single supplier at 20 percent of the projected total demand in the CBA, as will now be described.[28]

Each supplier offering a bid in a product category had to specify a bid price for every item in the category. A supplier's bid prices were summarized into a product category composite bid. The composite bid was calculated by multiplying the weight of each item in a product category by the supplier's bid price for each item, where the weight of each item was based on the national beneficiary utilization data for the individual item compared to the other items within that product category.

In each CBA separately, CMS arrayed the composite bids for a product category from lowest to highest. Proceeding from the lowest qualified bid, bids were accepted into the program until projected target demand for items in each CBA was met by all selectees collectively.[29] CMS used average 2007-2008 CBA-specific utilization as the base to which the projection factors of DME utilization per beneficiary and of CBA-specific enrollment were applied.[30] The suppliers' anticipated capacities (after applying the 20 percent total-projected-demand cap) were used in determining whether the demand target was achieved.

Item bid prices from the set of bids selected in this manner determined the new payment amount, which in competitive bidding terminology is called the "single payment amount" in the CBA. Specifically, for each item in the product category, the median bid price from the list of winning bids was set as the allowed charge for competitive bidding

The law specified that small suppliers must have the opportunity to be considered for participation in the program[31] and, pursuant to the statute, the rulemaking procedure established a target participation rate for small suppliers. CMS checked each competition's results to ensure that at least 30 percent of the winning bids came from small suppliers.[32] If more small suppliers were needed to reach the 30 percent small-supplier target, additional suppliers were selected, beginning with the qualified small supplier with a composite bid above but closest to the highest bid already accepted for the product category, and proceeding to the next-closest bid from a qualified small supplier, until the small-supplier target was achieved.

Before announcing the final list of program participants, CMS completed all contracting. About 8 percent of suppliers who were offered a contract following the bid review process declined to enter the new program. If a contract rejection caused a shortfall in target capacity in a CBA, the CBIC returned to the list of qualified bidders and made an offer to the next supplier in the bid array, until the necessary target capacity was reached. Next, the small supplier target was checked again. If the small-supplier target was not achieved, small supplier offers were made in the manner described above, until the target was reached. Neither the addition of small suppliers nor the additional contract offers that were needed to meet capacity targets caused a change in the single payment amount determined from the initial qualified bidder array.

Following the bid review process, CMS sent a detailed letter to each bidder that was not offered a contract, explaining the reasons why. If a bid was disqualified (for example, the supplier was not licensed), the letter explained the reasons and also mentioned whether the price would have caused elimination of the bid, absent disqualification. If the bid was not disqualified but the price was too high, the bidder was informed in the letter. A supplier inquiry process was also described in the letter; this process was available to suppliers who believed that they should not have been disqualified for the stated reasons. When a supplier submitted an inquiry, CMS then undertook a detailed re-examination of the bid information. If, during the course of the re-examination, CMS determined that a bid was incorrectly rejected, CMS offered a contract for that bid.[33]

Results of Competitive Bidding: Suppliers

CMS made public the list of contract suppliers on November 3, 2010. The agency awarded a total of 1,217 contracts to 356 suppliers. Because a supplier could compete in multiple product categories and areas, the number of contracts awarded was larger than the number of suppliers that won. Table 2 shows the number of bids and final number of contract suppliers in each product category by CBA. Across all product categories, mail-order diabetic supplies generated the highest number of bids in each of the nine CBAs. In each CBA, complex power wheelchairs generated the fewest bids (237 in total). Across all product categories

except one, Miami had the highest number of bids; the one exception was standard power wheelchairs, for which Dallas and Riverside each had a higher number of bids than Miami.

While a single product category (mail-order diabetic supplies) had the highest number of bids in every CBA, the number of contracts awarded by CBA was highest for oxygen supplies and equipment in four areas (Charlotte, Dallas, Miami, and Orlando). The number of contracts awarded was highest for enteral nutrients in four other areas (Cincinnati, Cleveland, Kansas City, and Pittsburgh). Standard power wheelchairs was the category with the greatest number of contract awards in Riverside. Although oxygen supplies and equipment generated among the lowest number of bids of any product category (628 total), the category produced the highest number of contracts awarded in total (259). In contrast, 107 of the 1,454 bids resulted in executed contracts for mail-order diabetic supplies. The relatively small number of contracts for mail-order diabetic supplies, despite the high prevalence of diabetes in the Medicare population, is likely related to the large scale of order fulfillment operations that is possible for a single firm supplying via mail order in this category and the large variety of sources that participate in this market. Among all CBAs, Miami, with the largest Part B enrollment, had the highest number of contract awards in each product category, with the exception of standard power wheelchairs. (Riverside had the most contracts awarded for standard power wheelchairs of all the CBAs.)

Table 2: Number of Qualified Bids Received and Number of Contracts Awarded, by CBA and Product Category: Round One Rebid

Area		Charlotte	Cincinnati	Cleveland	Dallas	Kansas City	Miami	Orlando	Pittsburgh	Riverside
Oxygen	Bids	50	45	53	98	31	150	86	48	67
	Awards	27	12	19	37	14	83	33	17	17
Power Wheelchairs	Bids	69	55	42	138	44	128	79	45	133
	Awards	19	15	15	26	9	19	12	16	43
Complex Power Wheelchairs	Bids	19	25	18	39	13	47	29	16	31
	Awards	7	6	6	6	6	9	7	6	6
Mail Order Diabetic Supplies	Bids	156	155	154	181	134	195	163	151	165
	Awards	9	14	14	11	9	16	12	12	10
Enteral Nutrition	Bids	54	65	67	110	45	151	71	53	81
	Awards	21	17	20	27	16	38	21	19	16
CPAP	Bids	59	54	60	115	42	152	92	54	78
	Awards	10	8	12	16	11	31	16	14	14
Hospital Beds	Bids	63	58	54	144	41	159	92	56	124
	Awards	11	11	11	17	11	30	10	12	10
Walkers	Bids	67	58	51	159	45	164	95	56	125
	Awards	12	11	14	25	15	28	18	16	15
Support Services (Miami only)	Bids						149			
	Awards						14			

Source: Competitive Bidding Implementation Contractor. Results at the time contract suppliers were announced (November 3, 2010).

Table 3 shows the final number of contracts and the percent awarded to small suppliers. In all nine CBAs, each product category had at least six contracts awarded, with one or more of the awards granted to a small business. Standard power wheelchairs represented the product category most likely to have small business percentages over 50 percent; in five of the nine CBAs (Charlotte, Dallas, Miami, Orlando, and Riverside), small businesses received at least 50 percent of the contracts awarded for that product category. The same five CBAs also had a substantial small business presence in one or more other product categories. For example, in four of the same five CBAs that had high small business percentages for standard power wheelchairs (Charlotte, Dallas, Miami, and Orlando), small businesses comprised at least 50 percent of the contracts awarded for walkers, while in the fifth CBA (Riverside), small businesses accounted for 47 percent of contract awards. Among all 9 CBAs, Miami had the greatest likelihood of having at least half of its contracts awarded to small businesses. In Miami, over 50 percent of contracts were awarded to small businesses in all product categories except mail order diabetic supplies.

Table 3: Total Number of Contracts Awarded and Percent Awarded to Small Businesses or Small Business Networks, by CBA and Product Category: Round One Rebid*

Area	Charlotte	Cincinnati	Cleveland	Dallas	Kansas City	Miami	Orlando	Pittsburgh	Riverside
Oxygen	27 33.3%	12 25.0%	19 31.6%	37 43.2%	14 28.6%	83 72.3%	33 54.5%	17 29.4%	17 29.4%
Power Wheelchairs	19 63.2%	15 33.3%	15 40.0%	26 69.2%	9 44.4%	19 68.4%	12 75.0%	16 37.5%	43 72.1%
Complex Power Wheelchairs	7 28.6%	6 33.3%	6 33.3%	6 50.0%	6 16.7%	9 88.9%	7 57.1%	6 33.3%	6 66.7%
Mail Order Diabetic Supplies	9 33.3%	14 35.7%	14 35.7%	11 36.4%	9 44.4%	16 37.5%	12 33.3%	12 33.3%	10 40.0%
Enteral Nutrition	21 28.6%	17 35.3%	20 30.0%	27 37.0%	16 31.3%	38 57.9%	21 42.9%	19 31.6%	16 31.3%
CPAP	10 40.0%	8 37.5%	12 41.7%	16 62.5%	11 45.5%	31 61.3%	16 50.0%	14 42.9%	14 35.7%
Hospital Beds	11 45.5%	11 27.3%	11 27.3%	17 47.1%	11 36.4%	30 66.7%	10 40.0%	12 33.3%	10 40.0%
Walkers	12 58.3%	11 45.5%	14 35.7%	25 60.0%	15 40.0%	28 75.0%	18 66.7%	16 43.8%	15 46.7%
Support Services (Miami only)						14 78.6%			

Source: Competitive Bidding Implementation Contractor. Results at the time contract suppliers were announced (November 3, 2010).

*All contracts awarded, after small-supplier additions, are included in the count of "total number of contracts awarded." Figures may vary from data published elsewhere which may use for the denominator the number of awards before adding small suppliers.

Suppliers that did not submit bids or did not receive a contract in response to a bid could elect to continue providing rented oxygen or other rental DME to customers who were already renting these items from them when the program began. Under this provision, known as grandfathering, grandfathered suppliers of oxygen and oxygen equipment must agree to accept the competitive bidding single payment amounts, while grandfathered suppliers of capped rental DME and inexpensive and routinely purchased items are paid the pre-existing fee schedule amount until rental payments end. Grandfathering does not apply to mail order diabetic supplies, which are not rental items, or to enteral nutrition, which is not DME. Grandfathered suppliers are not allowed to deny service to any individual beneficiaries who elected to continue receiving items included in the competitive bidding program from the suppliers. Suppliers wishing to be grandfathered had to notify Medicare in writing by November 17, 2010. In addition, they had to notify beneficiaries no later than November 17, 2010. Beneficiaries also had the option of switching to a contract supplier. Table 4 shows the number of suppliers, by CBA, that informed CMS that they elected to be grandfathered. A total of 4,679 suppliers notified CMS that they intended to be grandfathered.

Table 4: Number of Suppliers of Rental Equipment that Notified CMS that They Elected to Be "Grandfathered", by CBA: Round One Rebid

Area	Charlotte	Cincinnati	Cleveland	Dallas	Kansas City	Miami	Orlando	Pittsburgh	Riverside
Oxygen	19	44	44	92	36	115	60	66	60
Power Wheelchairs	17	17	10	49	13	128	26	18	35
Complex Power Wheelchairs	7	10	5	20	7	66	14	5	17
CPAP	42	53	51	109	45	162	78	65	64
Hospital Beds	55	54	54	129	44	182	77	75	90
Walkers	26	36	30	74	26	136	52	41	53
Support Services (Miami only)						123			

Source: Competitive Bidding Implementation Contractor

Note: Mail order diabetic supplies and enteral nutrition are excluded from this table because suppliers of these products were not subject to grandfathering.

Among the CBAs, Miami and Dallas had the highest number of grandfathered suppliers. This finding was consistent across all product categories, with Miami consistently having the highest number of grandfathered suppliers of any CBA, and Dallas consistently having the second highest number. (Support services are in the competitive bidding program in Miami only) Among product categories, hospital beds and accessories had the highest number of grandfathered suppliers. Other product categories with high numbers of grandfathered suppliers included oxygen supplies and equipment, and CPAPs.

Results of Competitive Bidding: Prices

The process of bid submission and review led to a generally large reduction in the fees for individual DMEPOS items. The following table summarizes the average price reduction for the items in each product category, and highlights the reduction for the leading item within the category, that is, the item with the highest allowed charges. The data in Tables 5 and 6 are not an estimate of savings, because they do not take into account unit volume.

Table 5: Average Percent Difference between Competitive Bidding Single Payment Amounts and Medicare Fee Schedule Amounts, by Product Category, All CBAs Combined: Round One Rebid

Product Category	Average Percent Difference for Product Category	Leading* Item within Product Category			
		Item, HCPCS, and modifier	Medicare Fee Schedule Price	Competitive Bidding Single Payment Amount	Percent Difference
Support surfaces (Miami only)	41.2%	Powered Pressure-Reducing Air Mattress (E0277 RR)	$629.05	$319.75	-49.2%
CPAP	34.2%	Continuous Airway Pressure Device (E061 RR)	$95.23	$58.23	-38.9%
Walkers and related accessories	33.7%	Walker, Folding, Wheeled, Adjustable or Fixed Height (E0143 NU)	$101.03	$66.13	-34.5%
Mail order diabetic supplies	33.0%	Blood Glucose Test or Reagent Strips For Home (A4253 NU)	$32.39	$14.62	-54.9%
Enteral nutrition	31.0%	Enteral Nutrition Infusion Pump - With Alarm (B9002 RR)	$115.13	$80.48	-30.1%
Hospital beds	29.5%	Hospital Bed, Semi-Electric With Mattress (E0260 RR)	$127.12	$80.35	-36.8%
Oxygen	25.2%	Oxygen Concentrator, Single Delivery Port (E1390 RR)	$175.79	$116.16	-33.9%
Standard power wheelchairs	19.4%	Power Wheelchair, Group 2 Standard, Captain (K0823 RR)	$3,641.40	$2,554.22	-29.9%
Complex power wheelchairs	10.5%	Wheelchair Accessory, Power Seating System (E1007 NU)	$7,910.85	$6,596.14	-16.6%

*Leading item is the item within the product category with the highest allowed charges.

Notes: RR=rental, NU=new purchase

Source: Abt Associates analysis of 2011 Medicare fee schedule,and single payment amounts for items included in the Round One Rebid of the DMEPOS competitive bidding program

Category price reductions varied (Table 5). The highest price reduction was for support surfaces, a category that includes pressure-reducing mattresses; this category was put up for bidding in the Miami CBA only. The average price came down by 41 percent, and the price

for the leading item in the category decreased by nearly half. Relatively large fee reductions also occurred for the continuous positive airway pressure (CPAP) machines, walkers, and mail order diabetic supplies categories, each with a price reduction of about one-third. The leading item in the mail order diabetic supplies category had a much larger reduction; the price for blood glucose test or reagent strips decreased by more than half. The smallest price reduction was for complex power wheelchairs, where prices declined an average of 11 percent; however, the price for the leading item in the category, a purchased power seating system, had a larger decrease, nearly 17 percent. The complex power wheelchair category had the smallest number of bids offered across the CBAs, a fact which may help explain the smaller reduction in comparison to price reductions in other categories. In addition to competition-related factors such as the number of bidders, profit-margin differences, which might be partly related to the size of fee reductions in recent years, are likely a cause of the product-related variation in the price reductions. For example, oxygen and power wheelchairs each experienced relatively large fee reductions in recent years.

There was less variation in the price reductions across geographic areas (Table 6), with a 13 percentage point difference in the average price reduction between the area with the smallest reductions (Kansas City) and the area with the largest reductions (Miami). Kansas City's results were influenced by relatively small reductions for complex power wheelchairs (2 percent) and hospital beds (17 percent). The variation in average price reductions across the areas is not explainable by differences in the pre-existing statutory fee schedules, as these schedules had a virtually uniform average price.

Table 6: Percent Difference between Competitive Bidding Single Payment Amounts and Medicare Fee Schedule Amounts, by Competitive Bidding Area

Competitive Bidding Area	Average Percent Difference
Miami	27.1%
Orlando	25.9%
Dallas	23.8%
Pittsburgh	20.6%
Riverside	19.3%
Cleveland	16.3%
Cincinnati	16.1%
Charlotte	15.5%
Kansas City	14.3%

Source: Abt Associates analysis of 2011 Medicare fee schedule, single payment amounts for items included in the Round One Rebid of the DMEPOS competitive bidding program

Examination of the price reduction averages shows that for five product categories there were differences across the CBAs that ranged from a factor of two (oxygen and hospital beds) to 11 (complex power wheelchairs) (data not shown). There was far less geographic variation in the price reductions for three product categories: mail order diabetic supplies; enteral nutrition; and CPAP.

The pattern of price reductions suggests that the particulars of both the local markets and characteristics of the product categories themselves contributed to the overall results of competitive bidding in the Round One Rebid. Enteral nutrition illustrates the influence of market individuality. Enteral nutrition has a national fee schedule, rather than state fee schedules. Despite the uniform fee system for this category, average price reductions still varied somewhat across the markets, from a low of 27 percent in Charlotte to a high of 34 percent in Cincinnati. As noted earlier, competition-related factors are another likely cause of the observed geographic variation.

3. Preliminary Results of Program Monitoring Activities

CMS has in place a set of activities program intended to monitor the implementation and performance of the competitive bidding program. Activities involve both routine management functions such as complaint resolution as well as data analysis. CMS's early analyses of the National Claims History and of inquiries to the 1-800-MEDICARE call center are discussed in more detail later in this section.

CMS' various program monitoring activities include:

- ***Routine beneficiary surveys:*** Feedback from beneficiaries in consumer satisfaction surveys will provide information on a continuing basis about customer satisfaction with suppliers. The initial survey was conducted June to August 2010 and the first follow up survey is to occur shortly.
- ***Formal complaint process:*** Coinciding with the program's commencement on January 1 of this year, CMS established a formal complaint process for beneficiaries, caregivers, providers and suppliers to use for reporting concerns about contract supplier or other competitive bidding implementation issues. CMS has procedures in place to route, investigate, track, and resolve complaints.
- ***Quarterly supplier reporting:*** Contract suppliers are required, as a term of their contract, to report each quarter on the specific brands of items they furnish to Medicare beneficiaries. Reports are due each calendar quarter, beginning with the first quarter of 2011. The information contained in the reports is used to update the supplier locator tool on the Medicare.gov website, and is used by beneficiaries and caregivers to identify contract suppliers that offer the brands they need. The quarterly reports will also help CMS evaluate supplier compliance with the non-discrimination contract requirement, which requires suppliers to make the same items available to Medicare and non-Medicare customers.
- ***National Competitive Acquisition Ombudsman:*** As required by MIPPA, CMS appointed an Acting Competitive Acquisition Ombudsman (CAO) in July 2009. The CAO responds to complaints and inquiries made by suppliers and individuals relating to the application of the competitive bidding program and provides an Annual Report to Congress. Prior to announcement of the contract suppliers, the CAO met with key stakeholders, such as the Program Advisory and Oversight Committee (PAOC), disability advocates, and others to identify potential issues and to be prepared to respond to inquiries and complaints. The CAO began to hear inquiries and complaints after contract suppliers were announced in November 2010.

- ***Regional office and local CBIC monitoring and outreach:*** Local CBIC staff are stationed among the CBAs. Along with regional office staff, they monitor transition activities, conduct environmental scanning, analyze trends, and identify and address any emerging issues. These monitoring and outreach responsibilities, which began on January 1, 2011, were added to their educational and site preparation functions ongoing since 2010 (discussed below in Section 4 of this report).
- ***Secret shopping:*** Since the new program began, CMS has conducted secret shopping on an ad hoc basis among contract suppliers. Secret shopping is a common business practice in which individuals pose as customers in order to evaluate retailers. The secret shopper program supports CMS in monitoring contract suppliers' performance and compliance with contract terms.
- ***Analysis of the National Claims History:*** Real-time analysis of the National Claims History is used to track health outcomes of groups of beneficiaries potentially affected by the competitive bidding program, identify utilization trends, monitor beneficiary access, address aberrancies in services, and target potential fraud and abuse. On June 30, 2011, CMS posted i***nitial results of the claims-based outcom***e monitoring on its website (see http://www.cms.gov/DMEPOSCompetitiveBid/01A3_Monitoring.asp#TopOfPage). Updated analyses will be posted monthly. Results from the first posting are discussed in more detail below.
- ***1-800-MEDICARE call center inquiry tracking:*** The 1-800-MEDICARE call center answers questions about the competitive bidding program; helps beneficiaries find sources of equipment and supplies; and addresses concerns of beneficiaries, their caregivers, and other members of the public regarding the competitive bidding program. Call center inquiries and complaints are being tracked weekly by the office of the national CAO. Complaints made about specific contract or noncontract suppliers are immediately referred to the CBIC for investigation. Other complaints are referred as appropriate to regional offices or CMS's central office. Results from the first 25 weeks of call center tracking data, for the period January 2, 2011, through June 25, 2011, are discussed in more detail below.

Preliminary Results from Health Outcomes Monitoring

CMS is conducting claims-based utilization and mortality outcomes monitoring in the nine Round One Rebid CBAs. Outcomes rates may be indicators of impacts of the competitive bidding program. For instance, poor oxygen service could lead to increased morbidity, potentially causing higher levels of health services utilization. CMS monitors a time series for a set of monthly utilization rates (beginning in January 2008) in each CBA and a specific comparison area. For example, the comparison area for the Pittsburgh, Pennsylvania, CBA is the Detroit, Michigan, area. CMS is monitoring rates of mortality, acute care hospitalizations, physician visits, emergency room visits, and skilled nursing facility (SNF) admissions, as well as the average number of acute care days per hospital admission and average number of days in a SNF per SNF resident. The health outcomes rates are graphed for visual inspection. Also, CMS is examining these data by making statistical comparisons of the monthly rates since January 2011, the commencement of the competitive bidding program, with the 36-month historical series (January 2008 through December 2010) to determine whether the rates remain stable. The data from each CBA's comparison area are used to check whether a CBA's rate change, if any, could reflect broader changes occurring across areas not subject to competitive bidding.

Three types of populations are being monitored using these rates. The first is the entire Original Medicare population in each of the nine competitive bidding areas (CBAs). The second population is Medicare beneficiaries who are users of one of the competitive bidding program product categories. The third population consists of one or more subsets of beneficiaries selected on the basis of health conditions, regardless of whether they are product users. These "access groups" are defined from a set of medical conditions specific to each product category, to focus the monitoring on beneficiaries at especially high risk of needing items in the product category. Through such focused outcome monitoring, CMS intends to detect any signs of access problems that potentially could arise under the new competitive bidding program. Monitoring condition groups also provides a way of making groups more comparable between time points and between the CBA and its comparison area. For example, for the oxygen product category, CMS defined a "Cardio-Pulmonary Narrow Access Group" consisting of the following conditions: Cardio-Respiratory Failure and Shock and Chronic Obstructive Pulmonary Disease. For oxygen monitoring, CMS also defined a "Cardio-Pulmonary Broad Access Group", consisting of Cardio-Respiratory Failure and Shock, Congestive Heart Failure, Major Congenital Cardiac or Circulatory Defect, Cystic Fibrosis, Chronic Obstructive Pulmonary Disease, and Fibrosis of Lung/Other Chronic Lung Disease.

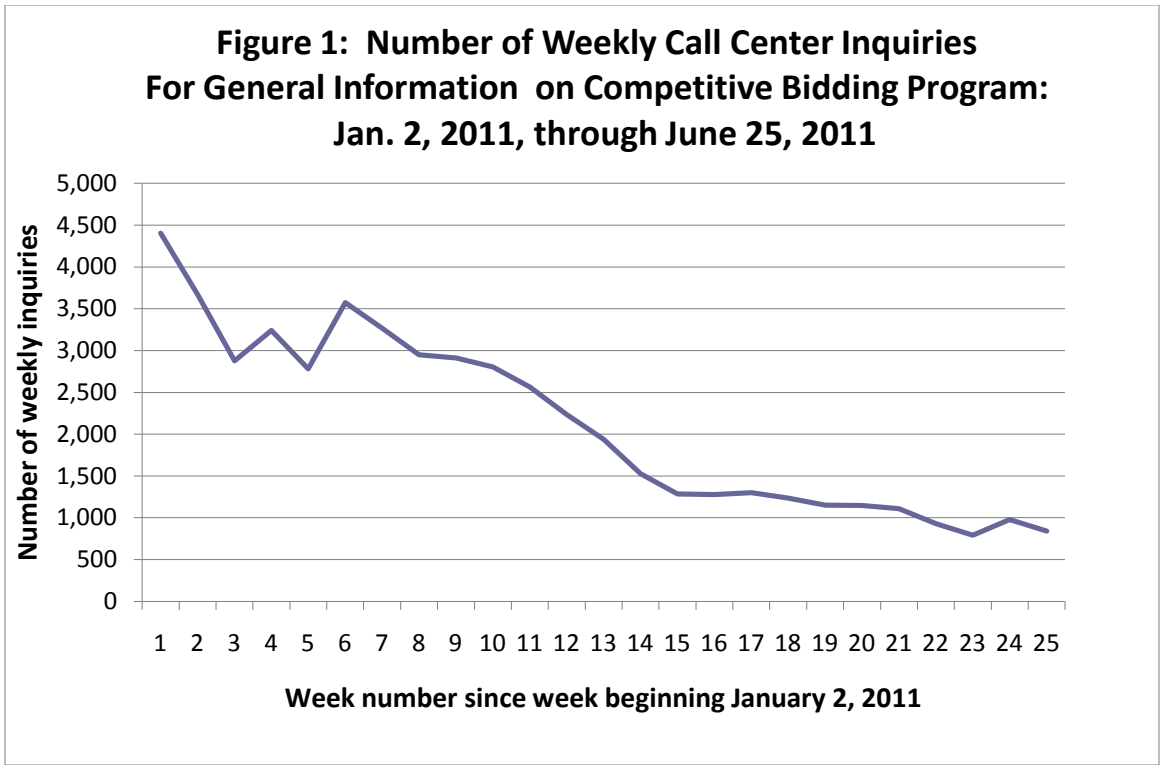
The many graphical displays produced for the monitoring program and released on June 30, 2011, reflect experience under the first three months of competitive bidding. There were no indications from these early data that raised concerns about impacts of the program on health outcomes. The rates will be updated and posted on the CMS website monthly, and will be subject to continuing review by CMS and the public. By evaluating the updates on a continuing basis, CMS will be in a position to detect changes in any CBA that might warrant an investigation into the circumstances and causes in the specific area involved. A

determination of whether competitive bidding was a likely cause of changes in statistical indicators would depend on the results of locally conducted investigations.

Preliminary Results from 1-800 MEDICARE Call Center Tracking

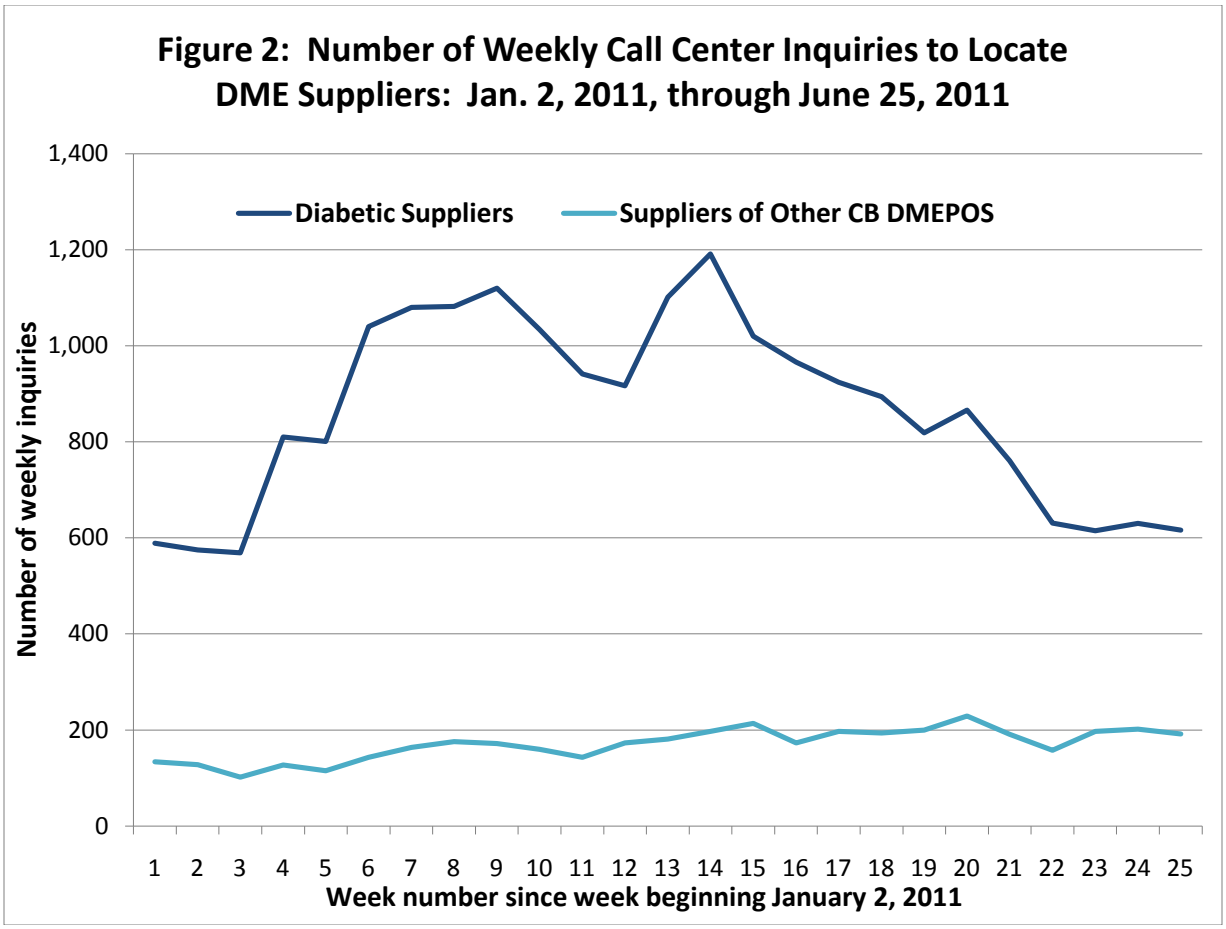
The 1-800-MEDICARE call center agents are equipped with scripts and other resources (such as hard copy contract supplier lists that can be sent in the mail) to assist beneficiaries with their information needs and with their acquisition of DMEPOS. The information generated in call center tracking data consists of "script hits," which are triggered when an agent in the call center consults a specific script in the course of assisting a caller. In some instances, notes made by the agent also trigger a record. Therefore, the counts of script hits and notations—called" inquiries" in the results below—do not necessarily represent unique callers or even unique calls to 1-800-MEDICARE, as a single encounter can generate multiple script hits or notations. Nevertheless, the data are useful for tracking the types of information beneficiaries and others require and the types of issues that lead to assistance-seeking. A system for classifying the inquiries was developed specifically for monitoring the implementation of the competitive bidding program in the Round One Rebid areas. The tracking system records the geographic location of the caller (e.g., Dallas CBA).

In the first 25 weeks beginning Sunday, January 2, 2011, 89,254 inquiries were logged.[34] This volume accounts for one percent of all script hits concerning all topics nationally, and less than one-half of one percent of total call center activity, in the same 25-week period. Eighty-five percent of the inquiries related to the competitive bidding program originated from one of the nine Round One Rebid CBAs. The volume of inquiries by CBA was proportional to the beneficiary population size. The leading inquiry topics, accounting for 59 percent of the inquiries, were classified to the following categories of general information needs: general information explaining the competitive bidding program (29 percent); how to use the on-line supplier locator tool (22 percent); and coverage dates, areas and equipment involved in the Round One Rebid competitive bidding program (8 percent). Since the first week of full tracking data (beginning January 2, 2011), the combined weekly count for these categories of inquiries has trended downward, from a high of 4,403 inquiries to a low of between 800 and 1,000 inquiries by week 22 (Figure 1). A decline in weekly volume of general information needs is likely indicative of decreasing needs for information about the new program as the areas move through the early, transition months of competitive bidding and information about the program diffuses through the beneficiary population.



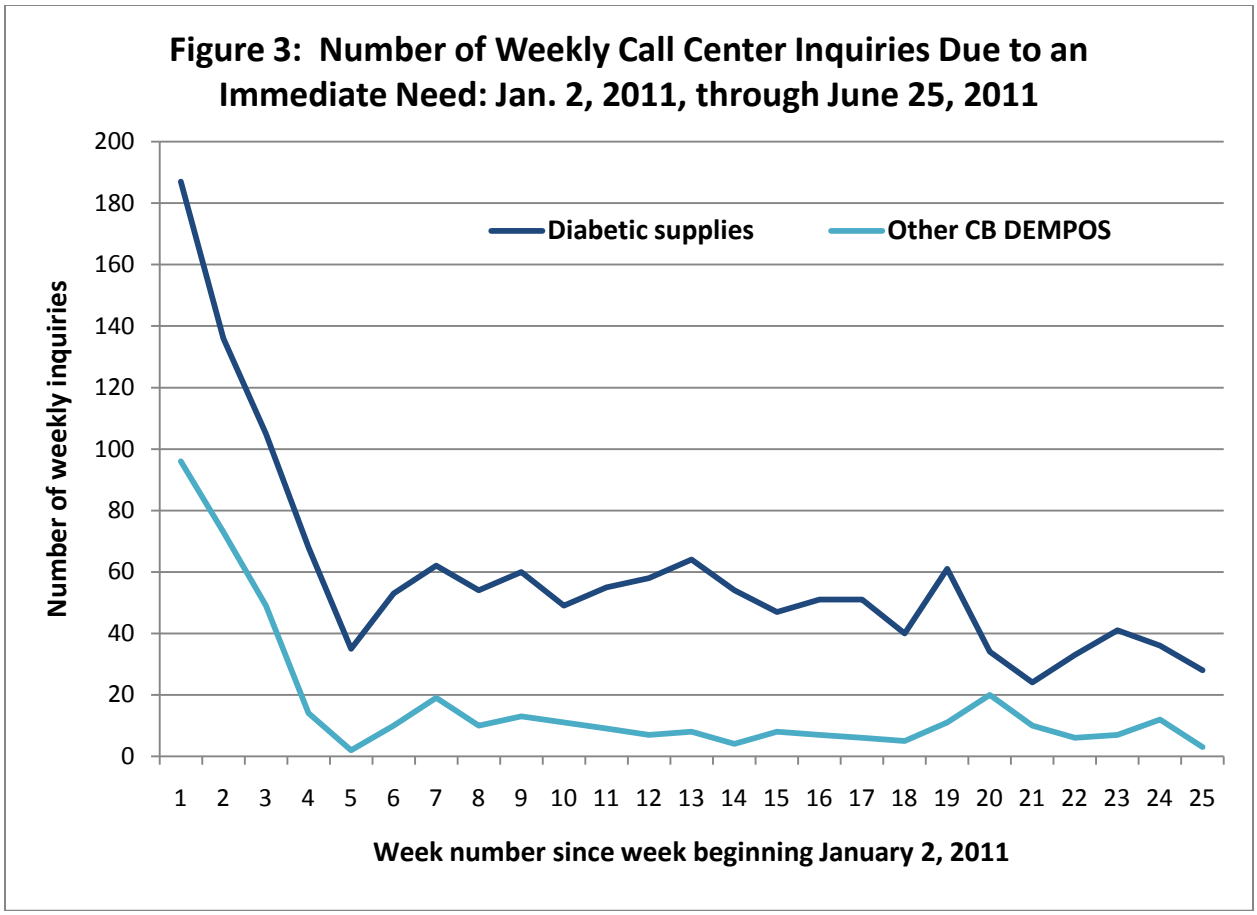
Source: 1-800-MEDICARE Call Center Tracking Data

Beyond the three in five inquiries classified to general information needs, another 24 percent of the inquiries involved obtaining assistance in locating a supplier of diabetic supplies. The volume of inquiries for this type of assistance during the first 25 weeks of the program increased from a level of about 600 weekly in the early weeks, to a peak of about 1,200 (week 14, April 3, 2011). Thereafter the volume trended down to the level seen in the early weeks (Figure 2). The individual CBA trend lines all showed the same general pattern of increasing and then decreasing numbers of inquiries. Some of the volume was attributable to beneficiaries who sought help locating a new mail order diabetic supplier that stocked diabetic test strips compatible with their blood glucose monitors. In some instances, this circumstance was resolved after contract suppliers arranged to replace beneficiaries' blood glucose monitors with a new one compatible with the supplier's test strips. In other instances, a new monitor was not necessary, as the call center was able to assist beneficiaries in finding a contract supplier of compatible test strips. In contrast to the 25-week trend for inquiries related to locating a diabetes-related supplier, the trend for obtaining assistance locating other types of DMEPOS has held fairly steady (about 200 per week) since the start of the program (Figure 2). The volume of inquiries resulting in assistance locating a diabetes-related supplier dominates the volume for other types of inquiries. One reason may be relatively high demand for diabetic supplies; the prevalence of diabetes among Original Medicare beneficiaries is about 25 percent.[35]



Source: 1-800-MEDICARE Call Center Tracking Data

The call center continually fields a low volume of inquiries generated by an immediate need for DMEPOS, defined as either one of the following two situations: (1) the beneficiary has a remaining supply of less than 2 days of oxygen or other life sustaining products; or (2) unless the beneficiary is able to access the medically necessary CB equipment in a timely way, the beneficiary's medical condition will be further exacerbated/worsened or result in increased pain or discomfort The volume of such inquiries accounts for only about 2 percent of all inquiries, but these inquiries are notable because they generally denote an urgent situation addressed by the call center. Figure 3 illustrates the trends during the first 25 weeks of 2011, according whether the immediate need concerned diabetes or the other types of DMEPOS included in the competitive bidding program in the Round One Rebid. As with inquiries in which a beneficiary receives assistance in locating a supplier, the category for diabetes supplies dominates immediate-need volume. Inquiry volumes related to immediate need for either diabetes supplies or other DMEPOS categories in the program dropped precipitously during the first four weeks of tracking. Immediate need inquiries so far are not associated with competitive bidding, based on examining the areas involved; approximately 2 percent of inquiries in each individual CBA and in the geographic category for all other areas concerned immediate need.



Source: 1-800-MEDICARE Call Center Tracking Data

In contrast to the downtrend in overall inquiries, the tracking data show that inquiries related to repairs rose from about 60 per week to about 120 per week during the first seven weeks of the program, and they have varied between 100 and 140 inquiries per week thereafter (data not shown). Inquiries to the call center about repairs often involve clarifying whether noncontract suppliers can be paid for repairs (yes). Repair-related inquiries account for about 3 percent of all inquiries in the tracking data. About four in ten of the repair inquiries concern standard power wheelchairs, and another two in ten pertain to CPAP equipment. For most product categories the weekly data involve small numbers that appear volatile, and so they do not clearly exhibit a trend consistent with the overall trend for repair-related inquiries. Repair-related inquiries might be expected to decrease as beneficiaries and noncontract suppliers become more familiar with the program.

A very small number of inquiries—about 116—have been classified as complaints and referred to either the CBIC (80 complaints), the regional offices (29 complaints), or the Medicare Administrative Contractor (7 complaints). Complaints referred to the CBIC concerned suppliers (including both contract and non-contract suppliers) and about one-quarter came from suppliers.

In conclusion, CMS is tracking call center inquiries because they are a timely and consistent source of information available about the progress of program implementation. Assuming

the time trends in the general-information inquiries are indicative of knowledge diffusion, results suggest that beneficiaries and their caregivers in the Round One Rebid CBAs have made strides in familiarizing themselves with the new competitive bidding program. If the inquiry volumes mean that relatively large numbers of beneficiaries use the call center for information and assistance, the detailed and timely nature of the product-related information being collected through the call center promises to reveal promptly any systematic problems in obtaining products and services in CBAs, should they arise.

The small number of complaints so far—about 116 over 25 weeks—is one kind of indication that beneficiaries who may be experiencing transition problems are finding resolution. The fact that immediate-need inquiries are not associated with CBAs is another sign that beneficiaries are experiencing a relatively smooth transition. Inquiry volumes are roughly proportional to CBA population sizes, which could mean that no area is experiencing any unusual adaptation problems. It is also worth noting that adaptation to the new program occurs at different times for different people. When it comes to established equipment services, most beneficiaries in CBAs are not suddenly exposed to the new program all at once, due to grandfathering of noncontract suppliers and the fact that service needs can often be sporadic. Tracking data for supplies such as mail order diabetic test strips are a better indicator of sudden exposure to the program, because grandfathering is not available, and because users have a regular need for refills of supplies.

4. Public Education

In January 2010, CMS began a phased strategy for educating the public about the aims of the DMEPOS competitive bidding program, and how the program would affect beneficiary relationships with suppliers and alter the process of obtaining needed medical equipment.[36] Experience with the demonstrations in 1999-2002 showed that effectively informing a unique audience is very important in ensuring that beneficiaries make a smooth transition to the new program. This audience consists of referral agents, that is, Medicare enrolled providers, physicians, therapists, discharge planners, social workers, pharmacists, and other treating practitioners who refer beneficiaries for DMEPOS services. Such stakeholders may be found within all kinds of settings, making them challenging to contact individually and as a group. At the same time, CMS designed a broad educational campaign to reach the entire spectrum of stakeholders, as described below.

CMS identified distinct stakeholder audiences for the educational campaign:

A. ***Beneficiaries***: Medicare beneficiaries and their caregivers.

B. ***Partners:*** Advocacy groups for the elderly and people with disabilities, such as Area Agencies on Aging, state health insurance programs (SHIPs), disease and caregiver organizations, minority service organizations, and employer groups.

C. ***Providers/Referral Agents:*** Medicare suppliers, pharmacists, practitioners, and providers such as hospitals and hospital systems; referral agents and industry organizations that serve as information resources for suppliers and referral agents.

D. ***Contract Suppliers****:* DMEPOS suppliers awarded contracts through competitive bidding

E. ***Non-Contract Suppliers:*** DMEPOS suppliers not awarded contracts through competitive bidding

F. ***Other Stakeholder****s:* Legislators, state/local government, employer groups

Table 7 summarizes the primary focus of outreach and education activities during each time period.

Table 7: Timing of CMS' DMEPOS Competitive Bidding Outreach and Education Activities

Dates	Focus of Outreach and Education
January 2010—June 2010	Program overview
July 2010	Announcement of payment rates
July 2010—October 2010	Pre-implementation information
November 2010	Announcement of contract suppliers
November 2010—April 2011	Beneficiary education
November 2010—April 2011	Implementation information

The outreach and education activities were conducted by the CMS Central Office, Regional Offices, and the CBIC. Central Office activities focused on outreach to national organizations representing beneficiaries, providers, contract and non-contract suppliers, referral agents, and other stakeholders. Regional Office activities, primarily in the nine competitive bidding areas, focused on outreach to state and local organizations, providers (e.g., hospital systems, physicians), disability and disease-based groups, beneficiaries, beneficiary advocates and district Congressional offices. The CBIC assisted CMS in educating contract suppliers. All of these activities were preceded by a great deal of communication and education internally in CMS, to prepare officials for their roles in the outreach process.

Examples of activities January 2010 through April 2011 are described below:

CMS Central Office Activities

Program overview for partners and providers: January 2010–June 2010. To provide an introduction to the program, CMS used the following types of methods to educate stakeholders: listserv messages; program and background information for

CMS spokespersons; conference calls to address healthcare providers' questions; Open Door Forums; briefings for key Congressional committees; and participation in a national conference of state health insurance programs. CMS also prepared training materials for providers and partners.

Pre-implementation: July 2010-October 2010. Timed to coincide with the release of the new fee schedules in the competitive bidding areas, education and outreach focused primarily on partners, providers, referral agents, and beneficiary service organizations, using the following types of methods: a toolkit (available from the CMS website[37]) containing a variety of documents meant for local distribution and oriented to the needs of different target audiences, such as referral agents, beneficiaries in specific situations (e.g., travelers), and providers and partners in the competitive bidding areas; information/training presentations at national meetings (e.g., Area Agencies on Aging convention), and other contacts with national organizations, such as the American Lung Association. CMS also prepared the 1-800-MEDICARE call center and the Medicare Helpline (serving Americans from various ethnic/cultural backgrounds) to provide information for telephone inquiries.

Implementation and beneficiary, referral agent, and supplier communications: November 2010–April 2011. Following announcement of contract winners, CMS focused more intensively on information for contract suppliers and beneficiaries in the nine CBAs. In early November, CMS mailed introductory letters and educational brochures to all beneficiaries in each of the nine Round One Rebid CBAs. Fact sheets, brochures, cards, and other materials were posted on www.CMS.gov and distributed to the CMS Regional Offices for use by local partners. CMS updated the on-line supplier locator on www.medicare.gov. On November 8, 2010, CMS held a national education call for non-contract suppliers, and on November 16, 2010, CMS held a national education call for referral agents. Additional fact sheets for the non-contract supplier community were released in November and early December 2010. In November 2010, CMS conducted training for Medicare fee-for-service (FFS) claims payment contractors. In December 2010, CMS mailed introductory letters and educational material to referral agents in each of the nine Round One Rebid CBAs. CMS continued to send listserv messages with program messages to referral agents, suppliers and national associations throughout November and December 2010. In late December, CMS also issued a mailing to a wide variety of referral agents in the nine CBAs to remind them that the program would start on January 1, 2011, and to direct them to on-line resources. At the same time, various materials (e.g., special articles) for public media, including social networks, were distributed in December 2010. Educational materials, in such forms as print ads in senior publications, fact sheets, and communications via social networks, were issued in the months following the program launch on January 1, 2011.

CMS Regional Office Activities

CMS Regional Offices (ROs) were responsible for local outreach to the target audiences. In Fall 2010, ROs conducted training sessions, briefings, and other presentations at sites throughout the nine CBAs. Table 8 shows a summary of the 428 official RO activities conducted between January 1, 2010, and December 31, 2010. The summary indicates that about half of the activities were verbal, live encounters. In addition, during this period, the ROs responded to 130 inquiries originating from the nine CBAs concerning the competitive bidding program.

Table 8: DMEPOS Competitive Bidding Outreach Activities of CMS Regional Offices: January 1, 2010, through December 31, 2010

Event /Product Type	Number
Mailing/Emailing/Listserv Messages to all audiences	167
Education and Outreach Meetings, Briefings, Webinars with providers, partners, referral agents	186
Exhibits with all audiences	16
Print Media	17
Beneficiary Education events	42
Total	428

Source: CMS Partner Outreach and Event Tracking System (POETS)

The Competitive Bidding Implementation Contractor (CBIC)

The CBIC assisted CMS in providing education to contract suppliers. The CBIC provided fact sheets, forms and instructions, and frequently asked questions on its website, www.dmecompetitivebid.com. The CBIC also communicated with contract suppliers via e-mails and listserv messages, and offered a toll-free customer service line. In addition, the CBIC has a local ombudsman in each of the nine CBAs who is available to assist contract suppliers, non-contract suppliers, referral agents, and others. In 2010, the CBIC hosted two educational teleconferences for contract suppliers covering a variety of issues regarding their responsibilities under the program.

5. Baseline Perspectives on DMEPOS Markets

The evaluation team conducted case studies in four CBAs (Dallas, Orlando, Riverside, and Cleveland) and three comparison areas (Houston, Tampa and San Diego) during Summer 2010. The purpose of the baseline case studies was to understand the context in which competitive bidding was taking place: the competitive markets for DMEPOS, the relationships between suppliers and referral agents, the level of awareness and knowledge about the competitive bidding program, and the anticipated effects of the program. The team held separate focus groups with suppliers and referral agents in each CBA to obtain perspectives of these two important groups of stakeholders prior to CMS' implementation of

the new program. Also, the team conducted key informant interviews with selected suppliers, knowledgeable industry sources (e.g., clinical specialty organizations) and advocacy-group representatives (e.g., senior legal rights groups) for the broader context in which they operate. For purposes of comparison, phone interviews were conducted with knowledgeable individuals in the three non-CBA areas selected for study. Suppliers usually represented small companies because the larger firms generally declined to participate. At the time of the case studies, participants who were suppliers and had submitted bids did not know whether they would be offered a contract. A total of 93 individuals participated.

The Referral Process

Referral agents, suppliers, and key stakeholders in each market shared the view that the number of DMEPOS suppliers in CBAs and comparison areas in 2010 was at least sufficient or, if not, more than adequate to meet Medicare's needs. Referral agents reported that suppliers compete aggressively, primarily in terms of delivery timeliness, product reliability, beneficiary training in equipment use, and fast response time for repair needs. Under a uniform fee schedule, of course, suppliers do not compete on price.

Referral agents generally maintain a list of the suppliers they prefer, built up from experience. In deciding on a supplier to match with a client, they also take into account the patient's preferences, geographic accessibility of the supplier, whether the supplier can provide all DMEPOS products needed by a patient ("one-stop shopping"), and whether the supplier accepts a broad range of insurance. Most patients depend on their referral agent to select a supplier for them and arrange delivery of the equipment.

Suppliers are the referral agents' main source of information, not only concerning equipment features, but also concerning payers' requirements, the competitive bidding program, and other DMEPOS matters.

Program Awareness and Knowledge

In mid-2010—before CMS began its intensive public education campaign in the nine CBAs—the various categories of case study participants exhibited certain information needs and misconceptions about the new program. Referral agents were not sure when and how they would obtain information about contract winners in their area. Few suppliers or referral agents understood that rural areas were excluded from the program launch. Few recognized the potential benefits of the program in terms of out-of-pocket savings for beneficiaries. Many participants assumed that CMS is solely responsible for all aspects of program design, failing to understand the extent to which the design was mandated in the law.

Case Study Subjects' Comments and Concerns About Effects of Competitive Bidding

The case studies revealed a widespread sense of concern about potential adverse outcomes under DMEPOS competitive bidding. These concerns pertained to service quality; product selection; transitioning to a new program; for referral agents, a change in job complexity and

workload; and, for suppliers, the uncertainty of operating under lower prices and how it would affect their business.

Coming from an environment in which supplier options are plentiful and lead to strong non-price competition, many participants feared that supplier performance would deteriorate when fewer suppliers are approved to provide DMEPOS. Referral agents thought that lower-quality products might be provided. Suppliers, for their part, believed the low prices offered by many bidders might make lower performance and poor product quality more likely.

Beneficiary advocates speculated that beneficiaries would potentially experience confusion in the transition to competitive bidding, and this would relate to a range of scenarios, such as beneficiaries not understanding their options when their current relationship is with a non-contracted supplier, beneficiaries being unable to negotiate the process of obtaining equipment when traveling outside their residential area, and beneficiaries encountering delays when seeking repairs from a supplier they have not used before.

Referral agents tended to be concerned about an increase in the complexity of their role and a bigger workload. They anticipated there would be fewer opportunities to refer beneficiaries for "one stop shopping." They were also concerned that if suppliers skimped on training patients in how to use equipment, the job would default to them. Referral agents also expected unusual demands for their help during the transition, as beneficiaries sought to find new suppliers.

Many DMEPOS suppliers indicated that, assuming they won a contract, they might not be able to sustain current levels of customer service at the prices they bid. They speculated that, as a result of competitive bidding, many smaller firms would likely close or be bought by larger companies.

Some suppliers described difficulties with preparing their bids, such as estimating costs and staffing needs, or profits, because they were unable to anticipate volume. They felt larger firms would be advantaged in the competition, largely because of differences of scale in their operations.

The evaluation team's baseline case studies will be followed up with additional case study activities with key informants (e.g., beneficiary advocacy groups) in mid-2011, focusing on experiences during the transition. In mid-2012, a final wave of case-study data collection will occur, and activities will include both focus groups of referral agents and suppliers, as well as key informant interviews.

6. Estimates of Savings

For this report, the evaluation team estimated annual savings in the nine CBAs in the first year of the program, based on analysis of the Medicare National Claims History. Two types of estimates were prepared. The first one estimates savings in allowed charges for Medicare and its beneficiaries combined (total savings), and the second estimates savings in the government's payments to providers (subsequently referred to as "program payments").

Implied in the difference between these two estimates is the savings to beneficiaries.[38] The claims data used to measure volume and prices in the absence of competitive bidding are from 2009, so results should be considered estimates of how much would have been saved if competitive bidding prices had been in effect in 2009. The use of claims from 2009 would only be a serious limitation of this approach if volume were to change substantially as a result of competitive bidding; the statutory statewide fee schedules upon which the savings are based have changed negligibly since 2009. When the project's assembly of the claims history is completed in two years, the evaluation study will address the question of program-associated volume changes in our final estimates of savings. Therefore, this report's estimate of savings is provisional.

Steps in Estimating Savings

Potential savings to Medicare associated with competitive bidding were estimated using the following steps:

- ***Measure payments using claims data:*** Medicare claims data for 2009 were used to measure allowed charges and Medicare's payments for competitively bid DMEPOS products and supplies, for beneficiaries in each CBA. For each HCPCS/modifier/CBA combination, total Medicare-allowed charges and the Medicare payment amount were calculated based on the claims data.
- ***Determine the percentage difference in per unit prices between Medicare fee schedule and competitive bidding:*** For each HCPCS/modifier/CBA combination, the percentage difference in per-unit prices between the 2009 Medicare fee schedule and the single payment amounts was calculated. This was computed as the absolute value of ((CB-MFS)/MFS)*100 percent, where CB is the competitive bidding single payment amount and MFS is the Medicare fee schedule payment amount.
- ***Estimate total and Medicare expenditures under competitive bidding****:* For each HCPCS/modifier/CBA combination, total allowed charges and Medicare expenditures, respectively, under competitive bidding were estimated, based on actual allowed charges and Medicare claims payment amounts, respectively. in 2009 and the percentage difference in Medicare fee-for-service and competitive bidding single payment amounts. For example, if actual Medicare allowed charges for a product were $5 million and the competitive bidding single payment amount was 50 percent lower than the Medicare fee schedule price, then estimated expenditures under competitive bidding would be $5 million * 0.5 = $2.5 million.

Allowed Charges and Expenditures Incurred in 2009

In 2009, Medicare allowed charges for all the product categories in the Round One Rebid CBAs totaled $381.27 million, with Medicare responsible for $298.83 million and beneficiaries responsible for the remainder through their payment of deductibles and copayments. Oxygen equipment and services accounted for 44 percent of total allowed charges, followed by standard power wheelchairs (17 percent), mail order diabetic supplies (14 percent), enteral nutrition products (12 percent), CPAP (5 percent) and hospital beds (5

percent). The remaining three categories, complex power wheelchairs, walkers, and support surfaces, accounted for approximately 1 percent or less of total allowed charges.[39]

Examination of allowed charges by CBA illustrates that expenditures roughly correlate with the number of beneficiaries in the area. Dallas led the nine areas with 22 percent of total allowed charges, followed by Miami (19 percent); these two areas have the largest numbers of Part B enrollees. Riverside, with 11 percent of the allowed charges, followed Dallas and Miami, although this area had fifth-largest population size. The remaining CBAs accounted for between 7 percent and 9 percent of the allowed charges, and also accounted for between 7 percent and 10 percent of the population total across the nine areas.

Estimated Savings

Overall, across all product categories and CBAs, we estimate the average percentage savings from competitive bidding to be 35 percent based on Medicare allowed charges (Figure 4), and 35 percent based on program payments (Table 9). Overall annual savings are estimated to be $134.6 million in Original Medicare based on allowed charges and $105.3 million based on program payments. These results suggest that beneficiaries in the nine CBAs would save the difference between these two amounts, or approximately $30 million, in their payments for deductibles and copayments. The following overview of the results focuses on allowed charges, because results for program payments are basically the same.

Across the nine product categories, savings percentages for allowed charges range from 18 percent to 55 percent. Savings in allowed charges are greatest for mail order diabetic supplies (55 percent) and support surfaces (49 percent), followed by CPAP (38 percent), hospital beds (36 percent), walkers (35 percent), oxygen (32 percent), enteral nutrition (also 32 percent), and standard power wheelchairs (29 percent) (Figure 4).

Savings for complex power wheelchairs are smallest, at 18 percent (Table 9); this category also had the lowest average reduction in fees (11 percent) relative to the statutory fee schedule amounts (Table 5).

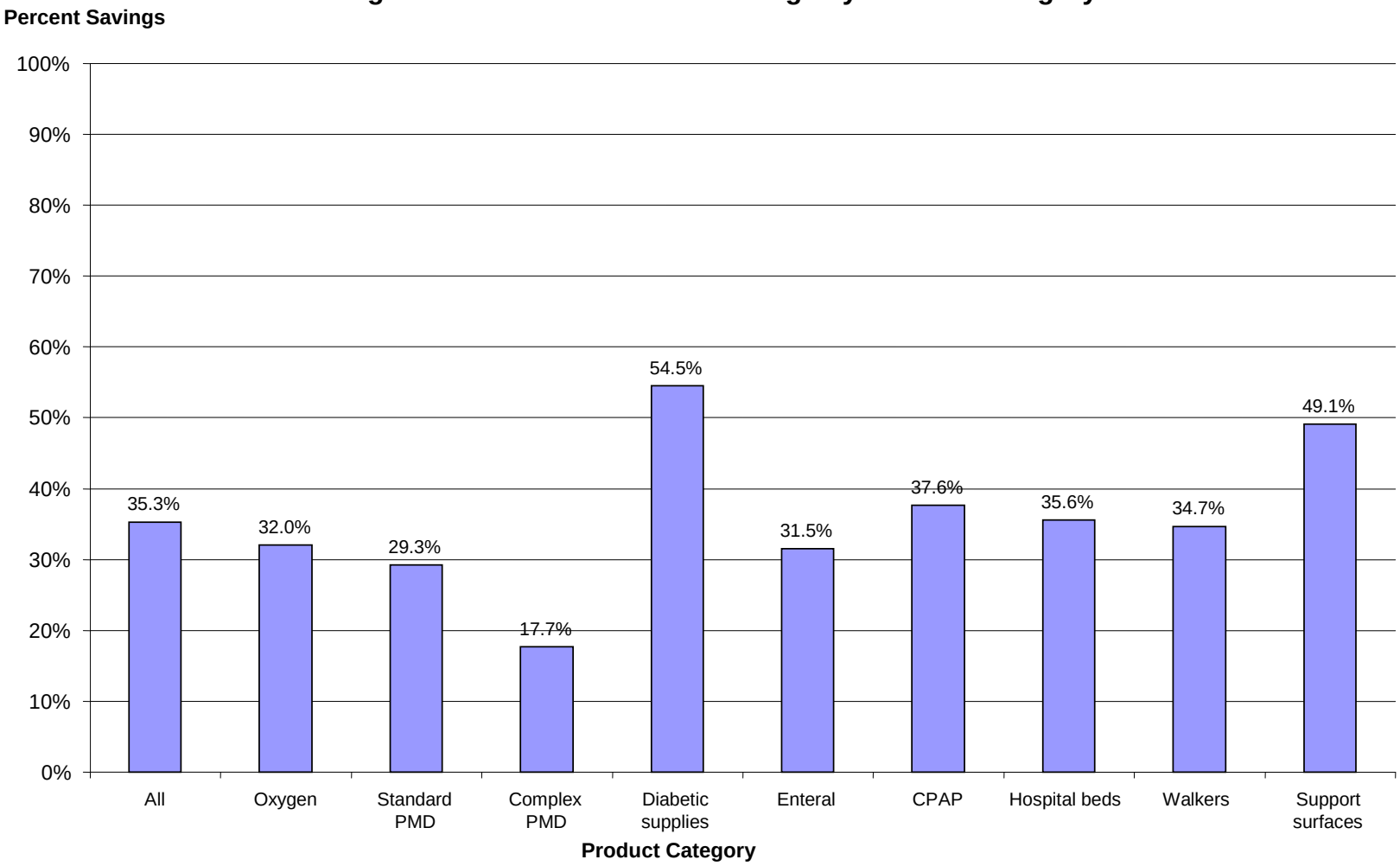
Oxygen accounts for $53.7 million of the estimated savings in total allowed charges, or 40 percent of the entire $134.6 million in estimated savings. Mail order diabetic supplies accounts for another 21 percent of the total savings in allowed charges, followed by standard power wheelchairs (14 percent) and enteral nutrition (11 percent) (based on data shown in Table 9). The remaining five product categories account for 14 percent of the savings.

Across the CBAs, estimated savings percentages range between 32 percent (Riverside) and 40 percent (Cleveland) (Figure 5 and Table 10). These Round One Rebid results suggest there may be possible regional differences in percent savings. The savings percents are relatively high in the northernmost CBAs (Cincinnati, Cleveland, and Pittsburgh). Not surprisingly, dollar savings are highest in the two CBAs with the largest Medicare populations, Miami and Dallas, which together accounted for 4 percent of the total allowed charges saved.

Examination of the individual DMEPOS items in terms of the savings realized in the Round One Rebid indicates that the items with the three largest allowed charges totaled together account for $89.7 million saved; the items are oxygen concentrators, blood glucose test strips, and semi-electric hospital beds (data not shown). The top 24 largest-saving items

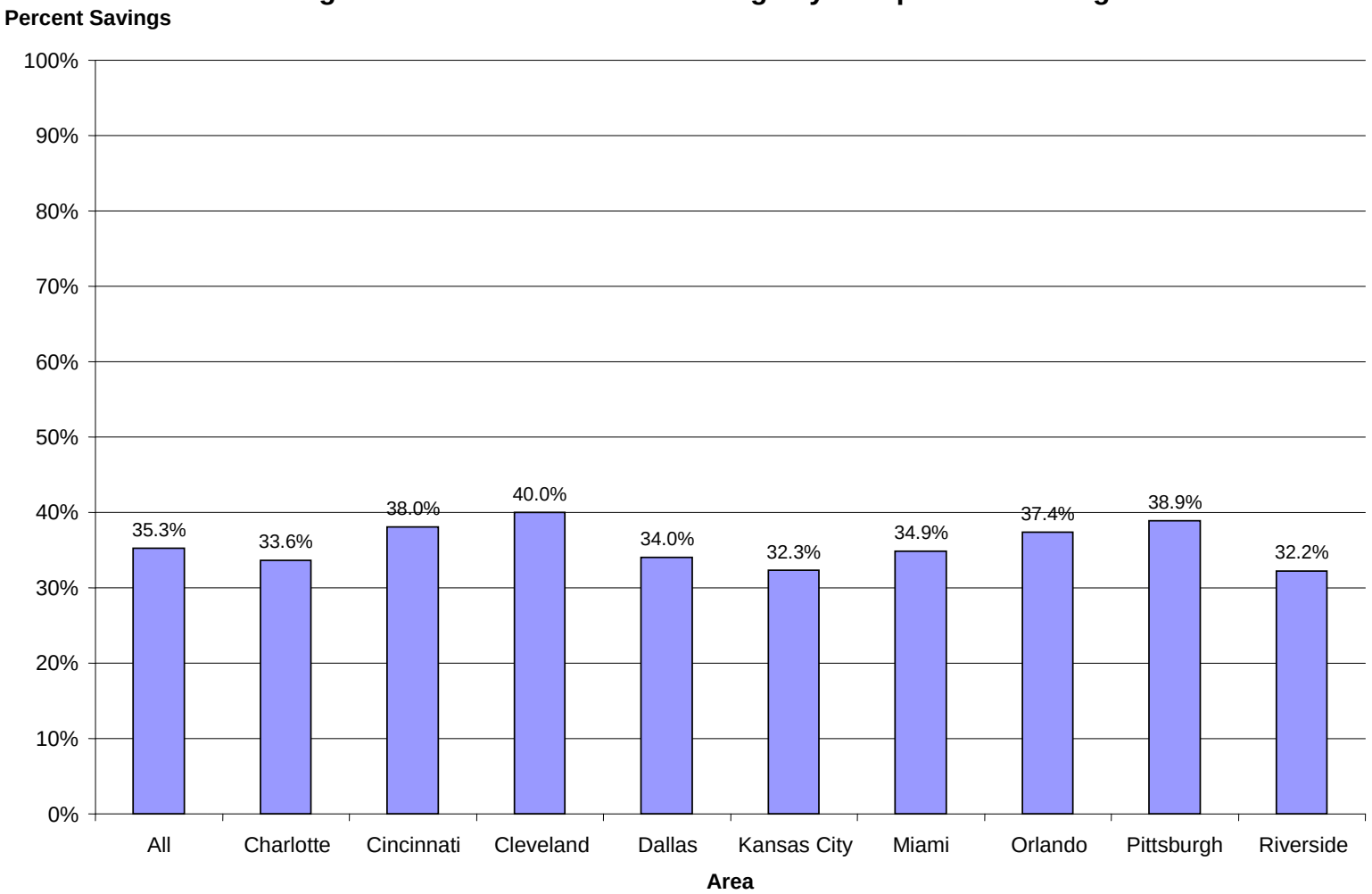
(across all Round One Rebid CBAs) collectively represent $130.7 million in savings. All product categories, with the exception of complex power wheelchairs, were represented in this list of top-saving items (data not shown).

Figure 4: Percent Medicare Savings by Product Category



Source: Abt Associates analysis of 2009 Medicare claims data and Medicare Round One Rebid single payment amounts

Figure 5: Percent Medicare Savings by Competitive Bidding Area



Source: Abt Associates analysis of 2009 Medicare claims data and Medicare Round One Rebid single payment amounts

Table 9: Summary of Estimated Savings If Competitive Bidding Were in Place in 2009, by Product Category

	Actual Medicare Costs		Projected Costs Under Competitive Bidding		Projected Savings Under Competitive Bidding			
Product Category	Allowed Charges	Medicare Expenditures	Allowed Charges	Medicare Expenditures	Estimated Savings (Based on allowed charges)	Estimated Savings (Based on Medicare expenditures)	Percent Savings (Based on allowed charges)	Percent Savings (Based on Medicare expenditures)
Total	$381,275,137	$298,833,361	$246,715,639	$193,545,900	$134,559,498	$105,287,461	35.3%	35.2%
Oxygen	$167,645,561	$130,469,889	$113,951,983	$88,721,539	$53,693,578	$41,748,350	32.0%	32.0%
Standard PMD*	$63,787,077	$50,740,239	$45,125,286	$35,891,864	$18,661,791	$14,848,375	29.3%	29.3%
Complex PMD*	$2,184,415	$1,727,481	$1,797,806	$1,421,264	$386,609	$306,217	17.7%	17.7%
Mail order diabetic supplies	$53,450,557	$41,305,175	$24,314,422	$18,789,971	$29,136,136	$22,515,204	54.5%	54.5%
Enteral	$45,059,160	$35,834,434	$30,843,417	$24,526,600	$14,215,743	$11,307,834	31.5%	31.6%
CPAP	$20,742,905	$16,252,110	$12,938,757	$10,138,559	$7,804,148	$6,113,551	37.6%	37.6%
Hospital beds	$19,710,165	$15,600,359	$12,691,496	$10,044,978	$7,018,669	$5,555,380	35.6%	35.6%
Walkers	$4,346,635	$3,448,310	$2,840,321	$2,253,384	$1,506,315	$1,194,926	34.7%	34.7%
Support surfaces	$4,348,662	$3,455,364	$2,212,153	$1,757,739	$2,136,510	$1,697,624	49.1%	49.1%

*PMD=Power Mobility Devices

Source: Abt Associates analysis of 2009 Medicare claims data, Medicare fee schedule, single payment amounts for items included in the Round One Rebid of the DMEPOS Competitive Bidding Program

Table 10: Summary of Estimated Savings If Competitive Bidding Were in Place in 2009, By CBA, Round One Rebid

	Actual Medicare Costs		Projected Costs Under Competitive Bidding		Projected Savings Under Competitive Bidding			
Area	Allowed Charges	Medicare expenditures	Allowed Charges	Medicare expenditures	Estimated Savings (Based on allowed charges)	Estimated Savings (Based on Medicare expenditures	Percent Savings (Based on allowed charges)	Percent Savings (Based on Medicare expenditures)
Total	$381,275,137	$298,833,361	$246,715,639	$193,545,900	$134,559,498	$105,287,461	35.3%	35.2%
Charlotte	$31,651,880	$24,767,344	$21,005,766	$16,451,499	$10,646,115	$8,315,846	33.6%	33.6%
Cincinnati	$32,782,825	$25,573,190	$20,314,216	$15,869,372	$12,468,609	$9,703,817	38.0%	37.9%
Cleveland	$34,332,078	$26,839,534	$20,611,924	$16,137,869	$13,720,154	$10,701,665	40.0%	39.9%
Dallas	$83,990,812	$65,801,028	$55,418,704	$43,451,808	$28,572,108	$22,349,221	34.0%	34.0%
Kansas City	$30,803,839	$24,027,436	$20,862,041	$16,288,571	$9,941,798	$7,738,865	32.3%	32.2%
Miami	$70,686,101	$55,737,572	$46,041,429	$36,311,094	$24,644,672	$19,426,478	34.9%	34.9%
Orlando	$31,775,522	$24,945,443	$19,896,745	$15,629,052	$11,878,777	$9,316,391	37.4%	37.3%
Pittsburgh	$24,939,738	$19,472,841	$15,230,064	$11,909,461	$9,709,673	$7,563,381	38.9%	38.8%
Riverside	$40,312,341	$31,668,973	$27,334,750	$21,497,174	$12,977,591	$10,171,799	32.2%	32.1%

Sources: Abt Associates analysis of 2009 Medicare claims data, Medicare fee schedule, single payment amounts for items included in the Round One Rebid of the DMEPOS Competitive Bidding Program

Illustrative Beneficiary Savings

The three items with the largest allowed charges are used in this section to illustrate the possible savings in out-of-pocket costs from a beneficiary's perspective (Table 11). The examples assume that the beneficiary is responsible for the usual 20 percent co-payment applied to Part B physician/supplier services. The fees resulting from the competition in each of the nine CBAs are shown in Table 11. For comparison, the 2011 statutory fee schedule amount, constant across all the states except in the case of the test strips (batch of 50 strips), is also shown. The test strip fees varied within two or three dollars of the most typical value selected for this illustration from the state fee schedules.

The comparisons show that beneficiaries renting oxygen concentrators in 2011 will save between $10 and $14 per month, depending on the CBA in which they reside. Oxygen concentrator rental payments can continue up to 36 months. Beneficiaries purchasing mail order diabetic test strips will save between $3.56 (Cleveland) and $3.90 (Riverside) per batch of 50 strips. Many diabetics will use several times that number of strips per month indefinitely, leading potentially to substantial savings over time. Finally, users of standard power wheelchairs will save between $54.83 per month (Riverside) and $63.61 (Orlando) on monthly rental payments, which end after 13 months.

7. Conclusions

The information in this Report to Congress suggests that savings from the DMEPOS competitive bidding program in its first year, 2011, will be substantial. The results from bidding in the nine Round One Rebid CBAs, across all nine product categories, are estimated savings of $134.6 million in allowed charges. Savings accruing to the Medicare program are $105.3 million and, to beneficiaries, approximately $30 million. More precise estimates will be made after data on actual realized volume in the CBAs are analyzed at the end of next year.

Based on our estimation method that uses the 2009 claims history, it appears that total savings percentages varied widely across the product categories, from a low of 18 percent to a high of 55 percent. Overall savings percentages varied somewhat across the 9 CBAs. The direct financial benefits to individual beneficiaries in terms of savings on co-payments vary. The examples in this report indicate amounts saved can be significant for individuals.

Other information in this report indicates that, as a result of the program design in the law, all stakeholders in the Medicare DMEPOS benefit can be expected to make adjustments to their habitual ways of addressing the needs of beneficiaries using medical equipment and supplies. Beneficiaries (and their caregivers) who need equipment and supplies covered by the new

Table 11: Illustrative savings per Medicare DME user: Three Selected DMEPOS Items, 2011

HCPCS	Description	Typical Fee Schedule Amount	Charlotte	Cincinnati	Cleveland	Dallas	Kansas City	Miami	Orlando	Pittsburgh	Riverside
E1390	OXYGEN CON-CENTRATOR, SINGLE DELIVERY PORT	$173.31	$122.12	$106.60	$103.00	$123.00	$125.00	$125.00	$115.00	$102.84	$122.90
	Monthly co-pay (20%)		$24.42	$21.32	$20.60	$24.60	$25.00	$25.00	$23.00	$20.57	$24.58
	Monthly savings (from $34.66)		$10.24	$13.34	$14.06	$10.06	$9.66	$9.66	$11.66	$14.09	$10.08
A4253	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS	$33.40	$14.50	$15.22	$15.62	$14.25	$13.94	$15.20	$14.50	$14.50	$13.88
	Co-pay (20%)		$2.90	$3.04	$3.12	$2.85	$2.79	$3.04	$2.90	$2.90	$2.78
	Savings (from $6.68)		$3.78	$3.64	$3.56	$3.83	$3.89	$3.64	$3.78	$3.78	$3.90

K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR	$545.69	$254.90	$269.00	$254.95	$244.82	$269.25	$236.69	$227.64	$270.00	$271.55
	Monthly co-pay (20%)		$50.98	$53.80	$50.99	$48.96	$53.85	$47.34	$45.53	$54.00	$54.31
	Monthly savings (from $109.14)		$58.16	$55.34	$58.15	$60.17	$55.29	$61.80	$63.61	$55.14	$54.83

Source: Medicare DMEPOS Fee schedule (http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp#TopOfPage) and Round One Rebid single payment amounts (http://www.dmecompetitivebid.com/palmetto/CBIC.nsf/docsCat/CBIC~Suppliers~Single%20Payment%20Amounts?open&cat=CBIC~Suppliers~Single%20Payment%20Amounts) . Monthly co-pay and savings estimate assumes beneficiary is responsible for 20% co-pay. Medicare fees used for comparison come from the 2011 fee schedule. Please see text for further details.

program are adapting to a new environment where information about who can provide reimbursed items and services is crucial because, unlike reimbursement for DMEPOS provided in non-CBAs, Medicare does not reimburse all accredited suppliers in CBAs, and instead only reimburses contract and grandfathered suppliers.[40] Not surprisingly, referral agents expect beneficiaries to rely on them for assistance to a larger extent than they used to, even as certain tasks, such as arranging multiple pieces of equipment, might become more complicated. Contract suppliers are likely seeking efficiencies and other cost-cutting measures in adapting to the substantial price reductions that resulted from the bidding process. At the same time, contract suppliers may be experiencing increased demand for their goods and services, as they compete with a smaller number of suppliers eligible to provide goods and services covered by the program.[41] Medicare and its agents and partners are only recently finished with a multi-faceted educational campaign that was designed to bring about a smooth transition for beneficiaries, their medical caregivers, referral agents, and suppliers. Various CMS-related components, such as program-specific ombudsmen, have new responsibilities in assisting CMS to resolve problems beneficiaries may encounter, and in responding to inquiries from suppliers concerning the application of the program.

CMS continues to collect information on the outcomes of the competitive bidding program in the Round One Rebid CBAs. Many more results beyond those available for this report are being studied. Surveys of beneficiaries, continued case study activities, and analysis of the National Claims History under competitive bidding are some of the most important data collection methods we will utilize. These materials will be analyzed to identify impacts of the new program on quality of services, access to services, beneficiaries' satisfaction with their suppliers, and expenditures. A final report of the entire research effort is expected to be released in early 2013.

Endnotes

[1] Original Medicare beneficiaries are those beneficiaries who have elected to stay in the traditional fee-for-service program, rather than enroll in any of the health plans run by private insurers under the program known as Medicare Advantage.
[2] Group 2 complex rehabilitative power wheelchairs and accessories are for patients who meet the medical necessity criteria for a powered mobility device, and have additional needs for postural positioning due to stroke, muscular dystrophy, or another health condition, or require pressure relief (to prevent pressure ulcers) due to inability to shift position.
[3] Group 2 support surfaces, mattresses, and overlays are pressure reducing, and designed to meet the needs of patients with large, severe, and/or numerous pressure ulcers.
[4]A list of the Round One Rebid items contained in each product category and the associated Healthcare Common Procedure Coding System (HCPCS) codes are available on the CBIC website at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home
[5] CMS initially conducted the first competition as required by MMA in 2007 but the resulting contracts were terminated as required by Section 154 of MIPPA. The subsequent round of bidding is known as the Round One Rebid.
[6] In this report, the separation of savings estimates into savings for beneficiaries and for Medicare, respectively, is intended to represent savings in payments to providers accruing to each in 2011. The separate savings estimates do not reflect the impact of the new program on Part B premium amounts and on net government expenditures after the Part B premium.
[7] In 2010, CMS indicated that the average savings from the Round One Rebid was 32 percent, but this figure did not consider the differing volumes of items furnished across CBAs. The 35 percent figure in this report is a better savings estimate, as it considers the actual volume in each CBA/product category in 2009.
[8] The MIPPA suspended the program in order to implement, among other changes, a change to the bid submission procedure so that bidding firms could request notice from CMS of any missing covered documents.
[9] 2009 Medicare and Medicaid Statistical Supplement (http://www.cms.gov/MedicareMedicaidStatSupp/10_2009.asp#TopOfPage)
[10] The Office of the Inspector General (OIG) has compared Medicare fees with costs of acquiring comparable equipment and has often found large differences (see, e.g., "A Comparison of Medicare Program and Consumer Internet Prices for Power Wheelchairs," OEI-04-07-00160, Oct. 2007). The Government Accountability Office (GAO) has concluded that the DMEPOS benefit is particularly vulnerable to improper payments stemming from abusive billing practices and weaknesses in provider enrollment procedures (GAO, "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments," Statement of Kathleen M. King, June 15, 2010, GAO-10-844T).
[11] Major additional program policy changes related to the DMEPOS benefit are summarized in Abt Associates Inc., Feb. 2011, "DMEPOS Competitive Bidding Program: Evaluation Research Results through December 2010."
[12] The demonstration in each site saved nearly 20%. Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, Tommy G. Thompson, 2004.
[13] GAO, "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments, "Statement of Kathleen M. King, June 15, 2010, GAO-10-844T
[14] Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues, Proposed Rule, FR 71, No. 83, May 1, 2006.
[15] Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues, Final Rule, FR 72, No. 68, April 10, 2007.
[16] Abt Associates Inc., Feb. 2011, "DMEPOS Competitive Bidding Program: Evaluation Research Results through December 2010."
[17] The evaluation study includes detailed before/after claims analysis and a before/after survey of beneficiaries who use DMEPOS. After all the follow-up information is collected, CMS will release a final analytic report addressing impacts in the evaluation areas listed in the legislation. We expect to release this report in early 2013.
[18] In its rulemaking (Proposed Rule,71 Fed. Reg. 25654 [May 1, 2006]; Final Rule, 72 Fed. Reg. 17992 [April 10, 2007]), CMS proposed and finalized a formula-driven methodology for selecting the phase-in CBAs based on population size, which utilized a number of other factors, such as beneficiary population, geographic distribution, and amount of DMEPOS allowed charges. MIPPA 2008 required the Round One Rebid to occur in nine of ten areas that CMS selected for the original Round One.

[19] See Endnote 1.
[20] MIPPA excluded negative wound pressure products, which was one of the original 10 product categories selected for the first round of bidding in 2007, from the Round One Rebid. MIPPA permanently excluded group 3 complex rehabilitative power wheelchairs from the program.
[21] Group 2 complex rehabilitative power wheelchairs and accessories are for patients who meet the medical necessity criteria for a powered mobility device, and have additional needs for postural positioning due to stroke, muscular dystrophy, or another health condition, or require pressure relief (to prevent pressure ulcers) due to inability to shift position.
[22] Group 2 support surfaces, mattresses, and overlays are pressure reducing, and designed to meet the needs of patients with large, severe, and/or numerous pressure ulcers.
[23]A list of the Round One Rebid items contained in each product category and the associated Healthcare Common Procedure Coding System (HCPCS) codes are available on the CBIC website at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home
[24] The reasons for this requirement are to prevent discrimination against Medicare patients and to help beneficiaries find the specific products they need. The makes/models information on the bids is the first collection of this information. Subsequent collection occurs during the contract period, as suppliers are required to file quarterly reports detailing the makes and models actually supplied to Medicare beneficiaries.
[25] In 24 Fed. Reg. 7653 (Feb. 19, 2009), as required by Congress in MIPPA 2008, CMS made certain changes for both the Round One rebid and subsequent rounds of the program, including a process for providing feedback to suppliers regarding missing financial documentation and a requirement that contractors disclose to CMS information regarding subcontracting relationships.
[26] Section 1847(b)(2)(A)(iii) of the Social Security Act prohibits the Secretary from awarding contracts unless the total amount paid to contractors in a CBA is expected to be less than would be paid otherwise. The implementing regulations required bid prices to be lower than fee schedule amounts to ensure compliance with the statute.
[27] To protect the integrity of the bidding process, CMS did not release the total financial score cutoff value that disqualified bidders.
[28] For a description of how expansion plans were evaluated, see http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Fact_Sheet_Capacity_and_Expansion_Plan.pdf/$FIle/Fact_Sheet_Capacity_and_Expansion_Plan.pdf . CMS reserved the right to reduce a bidder's anticipated capacity to historic levels based on results of the review.
[29] The demand target was based on recent demand provided in the CBA and projections of Medicare enrollment and growth in utilization.
[30] If the average annual growth in enrollment in a CBA from 2003 to 2008 was less than the national average annual percentage growth from 2008 to 2013, CMS applied the national average annual projected growth in Original Medicare enrollment. The total projected demand for the final 12 months of the contract period was used as the demand target.
[31] Elements of the small supplier policy established pursuant to the law included the following: (1) establishing the 30 percent small supplier target; (2) in consultation with the Small Business Administration, establishing a new, more representative definition of "small supplier" ($3.5 million or less in annual receipts); (3) allowing small suppliers to bid as part of a network in order to meet the program's requirements to furnish items and services to beneficiaries regardless of where they are located in a CBA; (4) not requiring suppliers to submit bids for all product categories, a requirement that might be difficult for some small suppliers to meet; (5) establishing financial standards and associated information collection requirements in a way that considered the needs of small suppliers; and (6) selecting at least five winning suppliers in an area if there are at least five qualified bidding suppliers, so as to prevent the largest suppliers from dominating a CBA.
[32] The final ratio of small suppliers could be less than 30% if there were not enough qualified small supplier bids submitted for a competition.
[33] As of June 1, 2011, the supplier inquiry process resulted in additional contract awards to 7 suppliers affecting the final supplier counts for 18 competitions. These additions are not included in Tables 2 and 3.
[34] Data for the first day of the program, Saturday, January 1, 2011, were not separately available at the time we analyzed the call center data. A total of 53 inquiries were made on January 1, 2011, bringing the total to 89,307..
[35] Schneider, KM, BE O'Donnell, and D Dean, "Prevalence of Multiple Chronic Conditions in the United States' Medicare Population," Health and Quality of Life Outcomes 2009, 7:82 (http://www.hqlo.com/content/pdf/1477-7525-7-82.pdf)

[36] This discussion covers the period beginning January 2010 and as such it does not cover CMS supplier education activities pertaining to the bidding process from the supplier perspective. An intensive bidder education program was completed before the bid window opened in 2009.
[37] See http://www.cms.gov/Partnerships/03_DMEPOS_Toolkit.asp.
[38] See end note 5.
[39] There was only one competition for support surfaces, in Miami.
[40] Accredited enrolled suppliers who did not win contracts can provide repair and maintenance services as usual, in addition to providing items that were not subject to competitive bidding.
[41] An increase in market share is not certain to occur for each contract holder. The evaluation of the DMEPOS competitive bidding demonstrations about ten years ago found that market share did not increase for every winning supplier. Reasons may have included a failure to undertake marketing efforts or to meet performance expectations of referral agents. Tommy G. Thompson, "Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," 2004.