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Committee on House Ways and Means

Subcommittee on Health

Medicare's Competitive Bidding Program For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies: "How the Program Is Impacting Patients, Suppliers, and Program Expenditures"

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By

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Introduction

Mr. Chairman Herger and members of the Subcommittee, I am Alfred J. Chiplin, Jr., Esq., a senior policy attorney in the Washington, DC office of the Center for Medicare Advocacy, Inc. (the Center). We are a national, not-for-profit organization that advocates on behalf of older people and people with disabilities to ensure access to fair, comprehensive, and affordable health care. We are a beneficiary-focused advocacy group. I thank you for the opportunity to come before you this morning.

The Subcommittee's continued focus on Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program is important. We at the Center share your overall concern that the DMEPOS program accomplishes its stated purpose of reducing Medicare costs while protecting beneficiary access to necessary and appropriate items of DMEPOS. Further, we agree that it is of critical importance to assess the Round 1 experience in the current nine Metropolitan Statistical Areas (MSAs), particularly as the Medicare agency prepares to implement Congress' directive to expand DMEPOS competitive bidding to an additional 91 MSAs in 2013.

We are pleased to see that the Centers for Medicare & Medicaid Services (CMS), the Medicare agency, is projecting savings to the Medicare Part B Trust Fund of $25.7 billion between 2013 and 2022 and a reduction in beneficiary coinsurance amount of $17.1 billion during this same period.[1] These savings are substantial for taxpayers and beneficiaries. We remain cautious, however, about beneficiary access to the scope and quality of DMEPOS items and services as suppliers jockey to do business in this new environment. We urge particular vigilance on the part of the Congress and CMS, particularly as more Metropolitan Statistical Areas (MSAs) are impacted by the DMEPOS competitive bidding program and as more items of DMEPOS become subject to competitive bidding. We think, nonetheless, that if properly implemented, including the development and expansion of appropriate beneficiary education and safeguards, the DMEPOS competitive bidding program could be a positive vehicle for ensuring that beneficiaries get the supplies they need while holding down costs to taxpayers.

In the main, the Center is of the opinion that the DMEPOS competitive bidding program should go forward; that program elements such as grandfathering, smaller supplier networks, and out of network repair and replacement rules could be made more understandable for beneficiaries. In addition, the Medicare agency should step up its efforts to educate beneficiaries about the DMEPOS competitive bidding program, including the development of a website specifically for Medicare beneficiaries. Education efforts should target MSAs as well as geographic areas not yet covered. This is especially necessary as misinformation about the program filters throughout the nation, making for confusion in all geographic areas, including those not currently affected by the DMEPOS competitive bidding program.

[1] See CMS' "Competitive Bidding Update—One Year Implementation Update April 17, 2012, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf.

Recommendations

As my introductory comments reflect, the Center is concerned about beneficiary education and access.

1. The Congress must mandate and the Medicare agency must provide clear information designed and directed specifically to beneficiaries. It can not be merely an add-on to suppler education activities. Necessary information includes defining what beneficiaries will need to know and do when their DMEPOS items need to be repaired or replaced, either in their MSA or while traveling outside that area; how to identify approved suppliers, the forms of acceptable notice; and how to initiate complaints and appeals when problems occur.

2. As we said in our 2010 testimony, CMS must engage in a vigorous and focused campaign to educate the beneficiary community. CMS must step up its educational campaign to ensure that Medicare beneficiaries of all ages are aware of the DMEPOS program and ongoing changes and modifications.

3. CMS must make clear to beneficiaries who reside in geographic areas not currently an MSA or a competitive bidding area (CBA) whether and how the DMEPOS rules affect them.

4. There must be an exploration by the Congress of how to address the caprices of DMEPOS suppliers who do not participate in Medicare yet supply items of DMEPOS. If a supplier is not in an MSA covered by the DMEPOS competitive bidding program, how will Congress and the Medicare agency protect unsuspecting beneficiaries as to notice requirements as well as extend its sanctions and oversight authority?

5. It will continue to be critical to provide clear information when new MSAs – and the CBAs within them – are added to the DMEPOS competitive bidding program. Likewise, there is the need for information for beneficiaries who obtain their DMEPOS products through mail-order suppliers.

6. There needs to be more clarity for beneficiaries about the DMEPOS rules for "grandfathered" suppliers.

7. The Congress and the Medicare agency must continue to speak with a loud and clear voice about the rules of the program, including the limits placed on supplier registration, certification, advertising, and on supplier solicitation of beneficiaries.

8. With respect to beneficiaries, data analysis of the DMEPOS program must look broader than a comparison of the number of beneficiary complaints filed. Over the years, our experience has been that even when serious access to service problems occur, few beneficiaries file complaints and even fewer enter Medicare's administrative appeals process. Data analysis must reflect this reality.

The Center's Ongoing Concerns

Thus far, we have not heard of specific access to DEMPOS problems. We expect, however, that as the program is expanded to the additional 91 MSAs as contemplated, we will hear of more problems. From our experience with other "roll outs" of Medicare changes and additions, we anticipate problems that relate to beneficiaries obtaining DMEPOS and related services from suppliers who are not certified as competitive bidding winners; about beneficiaries not getting adequate notice about the consequences of using suppliers who are not certified through the competitive bidding program; and about beneficiaries having overpaid for items of DMEPOS and for related services, given that they did not obtain their items and services from certified competitive bidding winners.

Access to DMEPOS

On September 15, 2010, I addressed issues of beneficiary access to DMEPOS at a hearing held by the House Energy and Commerce, Subcommittee on Health. The focus of that hearing was on DMEPOS Competitive bidding and implications for Quality, Cost and Access. The issues I raised at that time centered on assuring beneficiary access to necessary DMEPOS and related services and on the need to step up efforts to educate Medicare beneficiaries about the DMEPOS Competitive Bidding program.

In 2010, the Center heard confusion and conflicting conjectures from suppliers and beneficiaries about the consequences of the DMEPOS program, both positive and negative. Even so, our anecdotal experience was that suppliers were applying for certification and complying with the other DMEPOS requirements. What that raised for the Center was the need for clear, concrete, and factual information about the rules of the DMEPOS program and about beneficiary rights and responsibilities. The same is true today.

Access to Information about the DMEPOS program

A big concern in 2010 was that DMEPOS information for beneficiaries was lacking and incomplete and often difficult to find. The "Medicare.gov" website, for example, did not contain information about the DMEPOS competitive bidding program on its home page. Moreover, a search for durable medical equipment on the Medicare.gov website took one to a Medicare Supplier Directory. At that time, when a zip code in a competitive bidding area (CBA) was entered (33394, Ft. Lauderdale, FL, for example), the resulting page did not include information about the new program. And, at that time, the Medicare publication, "What You Should Know if You Need Medicare-covered Equipment or Supplies," revised June 2010, did not appear among the list of publications on the website icon for publications. We were concerned that one would only get to the appropriate section of the CMS website if one entered "DME competitive bidding." Then, as now, few beneficiaries know enough about the DMEPOS program to engage in a sophisticated search in order to obtain basic information.

In 2010, we were concerned that the DMEPOS program has been an enigma for the beneficiary community. Confusion reigned as providers vociferously opposed competitive bidding, including supplier certification, claiming that beneficiaries would not be able to obtain necessary

supplies and services. And, of course, Congressional action requiring that the Medicare agency engage in "Round 1" rebidding added to the confusion.

Limitations of the Medicare Website

I am pleased that once located, there is a fair amount of information available on the Medicare website about the DMEPOS program. Yet, accessing information remains a "scavenger hunt." I find few intuitive beneficiary focused prompts that lead to necessary DMEPOS information. Today, as in 2010, if one knows key words and phrases, one is likely to get to useful information.

I recognize that designing informational tools for beneficiaries about any subject – much less complex information – is not easy. There is no "one-size-fits-all" solution, to say nothing about the need to design materials for different cultures and for multiple languages, as well as trying to account for the various levels of understanding and comprehension that comprise current and future Medicare beneficiaries. Even so, it is important that the agency and the Congress give priority to educating beneficiaries about the DMEPOS program. As it stands, from looking at what has been done thus far, it feels as though educating beneficiaries has not been given the same level of attention as has been directed to the supplier community.

Diabetic testing supplies

The purchase of diabetic testing supplies remains an area of concern. As was noted in my 2010 testimony, under the DMEPOS rules, a Medicare beneficiary who is a permanent resident in a Competitive Bidding Area (CBA) may purchase diabetic testing supplies from a mail order contract supplier that serves the area in which he or she is a permanent resident or from a non-contract supplier in cases where the supplies are not furnished on a mail order basis. For such purchases, the diabetic supplies will be reimbursed at the single payment amount for the CBA where the beneficiary maintains a permanent residence. Moreover, when the diabetic supplies are not furnished through mail order, the suppliers will be paid the fee schedule amount. This process is confusing. It leaves beneficiaries unsure about pricing. Continuous monitoring and oversight is necessary to assure that problems are identified and resolved expeditiously.

In my 2010 testimony, I also emphasized the need for beneficiaries to have good information about their appeal rights – what to do when things go wrong and where they might obtain help in resolving disputes.

Using non-participating suppliers

We anticipate an increase in the number of suppliers who are not in an MSA covered by the DMEPOS program electing to be non-participating suppliers as defined in 42 USC §1395u(i)(2). Some, moreover, will elect not to participate in Medicare. Moreover, Medicare's limiting charge law, 42 USC§1395w-4(g), is not applicable to non-participating suppliers. Rather, the limiting charge law applies only to non-participating suppliers who supply services related to physician services.

Non-participating suppliers in areas not covered by the DMEPOS competitive bidding program are free to require the Medicare beneficiary to submit DMEPOS claims to Medicare and demand payment upfront – they are not subject to a particular written notice requirement – with Medicare reimbursing the beneficiary at the Medicare reasonable charge amount. Significantly, we encountered this very problem in December 2011. It is a problem that leaves the beneficiary responsible to pay the difference between Medicare's reasonable charge reimbursement (or the fee schedule amount) – whichever is less and the non-participating supplier's actual charge. Medicare will reimburse the beneficiary 80% of the Medicare reasonable charge amount (or the fee schedule amount) – whichever is less. The one saving grace for beneficiaries who use non-participating suppliers is that the beneficiary can submit the bill to Medicare and seek as much reimbursement as he or she can get, which, of course, reduces the beneficiary's out-of-pocket costs.

Once the DMEPOS program is fully implemented, and more DMEPOS items and more geographic areas are included in the DMEPOS program, beneficiaries should experience a greater reduction in DME out-of-pocket expenses as they will be required to use certified and registered DMEPOS providers in order to obtain Medicare-covered items of DMEPOS.[2] A beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a CBA unless the beneficiary has signed an advance beneficiary notice (ABN). See 42 C.F.R. §414.408(e)(3)(ii) (payment rules DMEPOS).

As we know, the consequences for beneficiaries when using a non-contract suppler are significant. Beneficiaries must be provided information about the importance of obtaining an Advance Beneficiary Notice (ABN) so that they fully understand the consequences of using non-contract suppliers, including possible waiver rights and higher payment rates. For example, contract-suppliers must accept assignment (that is, Medicare's reasonable charge amount, with the beneficiary being responsible for a twenty percent (20%) copayment amount, or the fee schedule amount) if they provide competitively-bid equipment to Medicare patients who reside in a CBA.

Grandfathered suppliers

Using "grandfathered" suppliers remains an issue for beneficiary education. As I stated in my 2010 testimony, Medicare's statutory and regulatory definition of covered DMEPOS suppliers is quite broad. We fear continued confusion among beneficiaries and suppliers about these rules. In many instances, beneficiaries will not know that that their physicians, nurse practitioners, and physical therapists might be subject to the regulations of the DMEPOS program, unless "grandfathered."

[2] Limited CMS data already supports this assumption. See CMS' "Competitive Bidding Update—One Year Implementation Update April 17, 2012, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf., at page 7.

Supplier Calls to Beneficiaries

We have not heard specific problems about the inappropriate use of cell phones, pages, and call-forwarding and other devices while away from their places of business. As more MSAs are in place, we anticipate abuses in this arena. The rules establish a complex scheme for determining whether such use is permitted for purposes of defining working from one's place of business as well as defining supplier networks within a CBA. Ongoing monitoring in this area is essential.

Finding a Supplier

As we noted in our 2010 testimony, we have concerns about DMEPOS program rules that beneficiaries must follow in finding or acquiring a DMEPOS supplier. Our concern remains that the burden on beneficiaries to understand suppler standards and requirements is too much. Even with a massive education campaign, beneficiaries will not be on an appropriate footing with suppliers to ascertain whether a suppler is in compliance with DMEPOS requirements. Under the DMEPOS rules, beneficiaries must change suppliers if their current supplier is not a competitive bidding winner or not otherwise grandfathered. Likewise, sorting suppliers and supplier networks will become increasing more difficult as the DMEPOS program expands, particularly as suppliers with smaller businesses link to form networks as provided under the statute.

Repair and Replacement Concerns

We have heard from advocates that beneficiaries are beginning to raise repair and replacement concerns as their current equipment ages. One concern in particular is about suppliers agreements for repair and replacement for those needing such services when outside the service area in which the DMEPOS was initially obtained. It is imperative that provider agreements, particularly where suppliers are not networked, are specific about responsibilities and clear about what the beneficiary is to do. We remain concerned about the burden on beneficiaries to know and make provisions for possible repairs or replacements in advance of travel. As currently established, repairs and replacements are to be made by the supplier in the CBA in which the beneficiary maintains a permanent residence, unless the supplier or the supplier network has arrangements with certified suppliers in the areas to which the beneficiary will travel.

Permanent residents within a CBA are required to obtain replacement of all items subject to competitive bidding from a contract supplier, including replacement of base equipment and the replacement of parts or accessories for base equipment that is being replaced for reasons other than servicing of the base equipment (for example, the need for a more durable piece of equipment given the beneficiaries weight or equipment usage). As was stated in my 2010 testimony, absent a strong effort to establish a comprehensive beneficiary education effort by the Medicare agency, beneficiaries in this circumstance may face serious access and payment challenges.

An additional repair and replacement concern is that some beneficiaries have complained that their suppliers are changing the products and items they carry and service, frustrating access to certain Medicare-covered items. A rationale for such changes, along with adequate notice to beneficiaries, is necessary.

Additional matters

CMS' April 2012 assessment of the DMEPOS program

Savings

The projected savings announced in CMS' April 2012 assessment is substantial. We hope these savings can be sustained with minimal impact on beneficiary access. Out-of-pocket savings to beneficiaries is an important access mechanism in promoting service and benefit utilization.

Admissions Data

We appreciate the focus of the Medicare agency on "secondary indicators of access to DMEPOS such as hospital admissions, emergency room visits, physician visits and admissions to skilled nursing facilities before and after the implementation of the DMEPOS competitive bidding model."[3] It is, nonetheless, important to state that more research and analysis, form a variety of disciplines and perspectives, is obviously necessary in order to establish a reliable and verifiable correlation between admissions data from specific health care settings and DMEPOS utilization and access.

Complaint Data

It is difficult to rely on the CMS complaint analysis as a measure of how well the DMEPOS competitive bidding program might be working. As said elsewhere in this testimony, few beneficiaries file complaints or enter the Medicare appeals process even when faced with serious access to and denial of service problems. We are not at all surprised at the overall low number of complaints received.[4] Random beneficiary calls are useful, as is adding DMEPOS fields on beneficiary satisfaction survey forms. Moreover, the Medicare agency is still relatively early on in the implementation of the DMEPOS program. Data about the program at this point should be viewed for the limited, but important, value it represents – a current snapshot.

Beneficiary Out-of-Pocket Savings

This area of the CMS report is the most exciting. We hope over time that cost-savings will increase and that access is not impacted by decreasing costs. Similarly, we remain concerned that providers carry a range of products within product categories and that beneficiaries are not inappropriately required to change brands or types of DMEPOS and supplies in order to stay within supplier costs parameters dictated by the competitive bidding process in local markets.

[3] Ibid., p. 4.

[4] Advocates and beneficiaries find it difficult to get through to the Medicare ombudsman for discussion and review of Medicare problems. Rather, Advocates and beneficiaries are generally shunted back to Medicare's "1-800" number, often experiencing long wait times. In addition, the quality of the information provided when one gets to a "live" person is often uneven.

DMEPOS Supplier Standards

In general, we are pleased to see the level of detail provided in CMS' DMEPOS supplier standards.[5] We think they will be helpful to all concerned. We hope that CMS will take particular elements of these standards and turn them into beneficiary education pieces, using a variety of media and approaches. This could potentially enhance beneficiary knowledge about the DMEPOS competitive bidding program.

Areas of the standards for discussion:

Standard # (b) 11 – Direct solicitation of a Medicare beneficiary

Solicitation of beneficiaries by unscrupulous persons is always a problem. CMS must have in place a comprehensive monitoring approach. The approach should be viewed expansively so as to include new forms of media as they emerge, particularly the internet and the use of so called "smart phones and related devices."

Standard #'s (b) 19 & 20 – Beneficiary Complaint Information

It is imperative to keep good data on beneficiary complaints, including the nature and frequency of the complaints. We are pleased that the standards require the name of the person receiving the complaint, a description of the problem, and a summary of the action taken to resolve the complaint. We are concerned that data about complaint resolution is sufficiently complete to allow an analysis of specific problem areas and the solutions proposed. In addition, we would like to see the data set expanded to include information about the resolution of complaints that are taken through the Medicare administrative appeals process.

Conclusion

We remain cautious about the DMEPOS program, but hope our concerns regarding beneficiary access and information will be addressed to ensure continued positive development of the program for beneficiaries and their families. Likewise, we hope the DMEPOS competitive bidding program will be able to sustain projected cost savings, while reducing fraud, waste, and abuse. We also note the concern of suppliers that use the DMEPOS competitive bidding program as an excuse to make business decisions – unrelated to the program – that adversely impact beneficiary access. Finally, we want to ensure beneficiaries have ready recourse when problems arise. We think, nonetheless, that if properly implemented, including expanded beneficiary education efforts and safeguards, the DMEPOS competitive bidding program could be a positive force toward beneficiaries getting the supplies they need while keeping down costs to taxpayers.

Thank you very much.

[5] See 42 C.F.R §424.58 (Accreditation – Conditions for Medicare Payment), http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=5558bf6fa8ad4534f53618e3304016c0&rgn=div8&view=text&node=42:3.0.1.1.11.4.6.10&idno=42.

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