JUN 29 2011

Congressional Letter – Status of Mandated Review of the Competitive Bidding Program

The following letter provides initial information about a statutorily mandated Office of Inspector General review of the competitive bidding program. Identical letters were issued to the Chairman and Ranking Member of appropriate Congressional committees.

This letter provides initial information about the Office of Inspector General (OIG) review of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) directed OIG to study the extent to which suppliers of DMEPOS items covered under the program solicit physicians to prescribe certain brands or modes of delivery of covered items based on profitability and to issue a report about the study by July 1, 2011.[1]

As you know, the program became operational in January 2011. Because of the short timeframe between program implementation and the due date, I informed the committees of jurisdiction in a letter dated June 30, 2010, that by July 1, 2011, OIG would issue an initial report describing our work to date and plans for completing the study. This letter serves as that initial report.

To date, OIG has undertaken several activities to address the issues identified in the mandate. We conducted multiple interviews with Centers for Medicare & Medicaid Services (CMS) staff and its contractors involved with the program. We then analyzed Medicare claims submitted for 2010 for covered products in the nine competitive bidding areas (CBA). We also interviewed numerous physicians in each of the nine CBAs who were most frequently indicated on 2010 Medicare claims as the prescribing physicians for DMEPOS items now covered under the program.[2]

BACKGROUND

The Competitive Bidding Program Began in Nine Areas in January 2011

Before the program began on January 1, 2011, suppliers competed to become Medicare contract suppliers for selected DMEPOS items within nine specific geographic areas.[3]

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[1] Section 302(e) of the MMA, as amended by § 154(c)(2)(C) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

[2] Although provisions in the MMA required that the initial phase of the competitive bidding program cover 10 CBAs, provisions in the MIPPA changed the requirement to 9 CBAs. See 42 U.S.C. 1395w-3(a)(1)(D).

[3] The competitive bidding statutory provisions require CMS to expand the program to an additional 70 metropolitan areas in the next phase of implementation. The expansion timetable has not been finalized.

Each CBA includes ZIP Codes surrounding the associated metropolitan area. The nine CBAs are:

- Charlotte, Gastonia, Concord (North Carolina and South Carolina);
- Cincinnati, Middletown (Indiana, Ohio, and Kentucky);
- Cleveland, Elyria, Mentor (Ohio);
- Dallas, Fort Worth, Arlington (Texas);
- Kansas City (Kansas and Missouri);
- Miami, Fort Lauderdale, Pompano Beach (Florida);
- Orlando, Kissimmee (Florida);
- Pittsburgh (Pennsylvania); and
- Riverside, San Bernardino, Ontario (California).[4]

CMS evaluated eligible suppliers' bids based on several criteria, including the bidders' financial stability, estimated capacity to provide DMEPOS products, and bid amounts.[5] CMS announced the winning bidders in November 2010 and awarded contracts to the suppliers that offered lower prices and met the program's quality and financial standards.[6]

These contractors then became the primary suppliers authorized to provide covered DMEPOS items to Medicare beneficiaries in each CBA. The program substantially reduced the number of DMEPOS suppliers authorized to provide covered items to beneficiaries in each of the nine CBAs. Suppliers not awarded contracts by CMS, known as noncontract suppliers, may continue to receive payment for providing covered items only in certain circumstances.[7] Additionally, noncontract suppliers may be grandfathered to continue providing a small number of covered rental items for existing customers.[8] Noncontract suppliers may continue to provide beneficiaries with DMEPOS items and services not included in the program.

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[4] CMS, *Facts About the DMEPOS Competitive Bidding Program Round 1 Rebid Competitive Bidding Areas (CBAs)*. Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Fact_Sheet_Competitive_Bidding_Areas.pdf/$FIle/Fact_Sheet_Competitive_Bidding_Areas.pdf on June 10, 2011.

[5] CMS, *DMEPOS Bid System (DBidS) Application: Getting Started.* Accessed at http://www.dmecompetitivebid.com/cbic/cbicrd1.nsf/files/DBidS_Getting_Started_Checklist.pdf/$FIle/DBidS_Getting_Started_Checklist.pdf, on June 10, 2011. See also 42 CFR § 414.414 and Social Security Act (SSA) § 1847(b)(2).

[6] CMS, *Contract Suppliers Selected Under New Medicare Program.* Accessed at http://www.cms.gov/apps/media/press/release.asp?Counter=3861 on March 11, 2011.

[7] SSA, § 1847(a)(7); 42 U.S.C. § 1395w-3; and the *Medicare Claims Processing Manual*, Pub. 100-04, ch. 36, § 20.6.

[8] SSA, § 1874(a)(4); Medicare Claims Processing Manual, Pub. 100-04, ch. 36, § 20.6; CMS, Exemptions to the Requirement to Be a Contract Supplier for Furnishing Competitive Bidding Items and Services Fact Sheet. Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Fact_Sheet_Exemptions.pdf/$FIle/Fact_Sheet_Exemptions.pdf on June 6, 2011.

The Competitive Bidding Program Reduces Medicare Payments
Using the bids submitted by suppliers, CMS set a single payment amount for each DMEPOS item in each CBA. This single payment amount replaced the prior Medicare fee schedule amount.[9] CMS stated that the new methodology is intended to "reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services from qualified suppliers."[10] CMS estimated that these new, lower payment amounts would result in an average cost savings of 32 percent for the covered products across the nine CBAs when compared to the 2009 fee schedule payment amounts.[11]

The DMEPOS items included in the program are generally high-cost and/or high-volume products.[12] There are 253 individual products grouped into the following 9 product categories, with each product category consisting of multiple related items:

- oxygen, oxygen equipment, and supplies;
- standard power wheelchairs, scooters, and related accessories;
- complex rehabilitative power wheelchairs and related accessories;
- mail-order diabetic supplies;
- enteral nutrients, equipment, and supplies;
- continuous positive airway pressure devices and respiratory assist devices and related supplies and accessories;
- hospital beds and related accessories;
- walkers and related accessories; and
- support surfaces (Group 2 mattresses and overlays in the Miami CBA only).[13]

Physicians May Prescribe Specific Brands and Modes of Delivery
In general, DMEPOS suppliers are not required to provide a specific brand or mode of delivery for a product when they fill a prescription for a DMEPOS item.[14] For example, if a physician prescribes diabetic test strips for measuring a beneficiary's blood glucose level, the supplier has discretion to provide any brand of test strips. However, the MMA established a special provision, known as the physician authorization process, to ensure that beneficiaries have access to specific brands or modes of delivery of covered items

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[9] SSA, § 1847(b)(5); *Medicare Claims Processing Manual*, ch. 36, § 40.1.
[10] Medicare Claims Processing Manual, ch. 36, § 10.
[11] CMS, *DMEPOS Competitive Bidding – Round 1 Rebid – Weighted Average Savings*. Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Weighted_Average_Savings.pdf/$File/Weighted_Average_Savings.pdf on June 10, 2011.
[12] CMS, *General Overview of the Final Rule for Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*. Accessed at https://www.cms.gov/DMEPOSCompetitiveBid/Downloads/DMEPOSRegSumm.pdf on June 10, 2011. See also 72 Fed. Reg. 17992, 18021 (Apr. 10, 2007).
[13] CMS, *DMEPOS Competitive Bidding–Round 1 Rebid Product Categories and HCPCS Codes*, Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/HCPCS_Codes.pdf/$File/HCPCS_Codes.pdf on June 10, 2011. Group 2 support surfaces include powered pressure-reducing mattress overlays and replacement mattresses.
[14] SSA, § 1847(a)(5); *Medicare Claims Processing Manual*, ch. 36, § 30.4.

when a physician determines that they are needed to avoid an adverse medical outcome.[15] Under this process, when a physician prescribes a specific brand or mode of delivery, the contract supplier must furnish the item as prescribed, consult with the physician to find an appropriate alternative brand or mode of delivery, or assist the beneficiary in finding a contract supplier that can furnish the prescribed brand or mode of delivery.[16]

Suppliers May Have Incentives To Limit Brands and Modes of Delivery

The physician authorization process may create an incentive for suppliers to solicit physicians to change their prescriptions to maximize profitability, irrespective of the patients' needs. This could occur, for example, if suppliers cut their costs by stocking a limited number of brands for items covered under the competitive bidding program. When a physician prescribes a specific brand that a supplier does not stock, the supplier might have to incur additional costs or pass the business to another supplier to ensure that the beneficiary receives the item as prescribed. This provides a financial incentive for suppliers to persuade physicians to change their prescriptions. The supplier is not allowed to ignore the prescription or compel the physician to change the prescribed brand or mode of delivery, but may consult with the physician or use the physician authorization process described above.

PROGRESS TO DATE AND PLANS FOR FINAL REPORT

OIG Is Using Data Analysis and Physician Interviews To Address the Mandate

Before beginning this study, we reviewed all statutes, regulations, and other material relevant to the rules, history, and operations of the competitive bidding program. Additionally, we conducted multiple interviews with CMS staff and contractors, including the competitive bidding implementation contractor and the pricing, data analysis, and coding contractor, to gather additional insight about vulnerabilities related to brands and modes of delivery.

Medicare Claims Analysis. We analyzed 2010 Medicare DMEPOS claims to better understand the claims data. We calculated the volume and dollar amounts of claims for all DMEPOS items now covered under the program and identified physicians in the nine CBAs who frequently prescribed these products. As more 2011 Medicare claims data become available, we will compare them to the 2010 claims data to identify changes in beneficiary utilization of covered items under the program, calculate the volume of payments for the covered items, and identify any potentially problematic shifts in Medicare billing. We will include this analysis in the final report.

Physician Interviews. Because Medicare claims do not record brand information and contain only limited information about mode of delivery, we conducted additional data collection regarding supplier solicitation of physicians. We began by conducting structured prestudy interviews with numerous physicians who prescribed the largest dollar amount of covered DMEPOS items in each CBA. As more 2011 claims become available, we will select a larger representative sample of physicians in each CBA to

[15] MMA, P.L. 108-173, § 302(b)(1).

[16] Medicare Claims Processing Manual, Pub. 100-04, ch. 36, § 30.4.

survey about their experiences since the program began in January 2011. For our final report, we will determine to what extent physicians prescribe specific brands or modes of delivery for covered DMEPOS items; whether suppliers have solicited them regarding brand or mode of delivery; and if so, under what circumstances.

Our final report will include our analysis of both Medicare claims and physician responses to our survey. We will continue to meet with CMS officials about the program and our report findings.

Sincerely,

/S/

Daniel R. Levinson
Inspector General