



Turning a Challenge Into an Opportunity: How To Succeed With Competitive Bidding

Presented by:

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Educational Objectives

**Name of Presentation: Turning A Challenge into an Opportunity:
How to Succeed with Competitive Bidding**

Name of Presenters: Jeffrey S. Baird, Esq. and Denise Fletch, Esq.

1. The attendee will learn about the statutory authority behind competitive bidding.
2. The attendee will understand the legislative and regulatory requirements of competitive bidding.
3. The attendee will learn about how the previous two competitive bid test projects affected suppliers and beneficiaries.
4. The attendee will learn about the steps it needs to take to enhance its chances of being awarded a bid contract.
5. The attendee will understand the steps it needs to take in order to become accredited within the time frame mandated by the Medicare Modernization Act.

**NATIONAL COMMUNITY
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**TURNING A CHALLENGE INTO AN
OPPORTUNITY: HOW TO SUCCEED
WITH COMPETITIVE BIDDING**



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**TURNING
HOW TO**

**TURNING A CHALLENGE INTO AN OPPORTUNITY:
HOW TO SUCCEED WITH COMPETITIVE BIDDING**

by Jeffrey S. Baird, Esq. and Denise M. Fletcher, Esq.

I. COMPETITIVE ACQUISITION AUTHORITY

- A. Section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) authorizes the Secretary of Health and Human Services (“Secretary”) to utilize competitive acquisition authority, as outlined in the U.S. Code Section 1847(a).

- B. Section 302(b)(1) of the MMA requires the Centers for Medicare and Medicaid Services (“CMS”) to replace the current durable medical equipment (“DME”) payment methodology for certain items with a competitive acquisition process with an intention to improve the effectiveness of CMS’ methodology for setting DME payment amounts.
 - 1. This new bidding process will establish payment amounts for certain DME, enteral nutrition, and off-the-shelf orthotics.

 - 2. According to Congress, the intent of competitive bidding is to provide a way to harness marketplace dynamics to create incentives for suppliers to provide quality items and services in an efficient manner and at reasonable cost.

- C. According to Congress, the Medicare DME Competitive Bidding Program has five objectives:
 - 1. To operationalize competitive bidding for DME and to use this to determine appropriate prices for categories of DME covered by Medicare Part B;

 - 2. To protect beneficiary access to quality DME throughout the program;

 - 3. To reduce the amount Medicare pays for DME and bring the reimbursement amount more in line with that of a competitive market;

 - 4. To limit the burden on beneficiaries by reducing their out-of-pocket expenses; and

5. To mitigate proliferation of use of certain items of DME by contracting with suppliers that engage in a business model that is beneficial for the program and for Medicare beneficiaries.

II. LEGISLATION/TIMELINE

- A. The steps and timeline for the development of the DME competitive bidding program are as follows.
 1. Section 302 of the MMA requires bidding to occur in ten of the largest Metropolitan Statistical Assets (“MSAs”) in 2007, in 80 of the largest MSAs in 2009, and additional areas after 2009. According to the April 24, 2006, proposed rule, the first round of bidding will take place October 1, 2007.
 2. The process to design and implement competitive bidding began in the summer of 2004 with the awarding of a contract to RTI/Palmetto.
 3. A proposed rule was released May 1, 2006. The proposed rule identified the formula for picking the MSAs but did not designate the sites. A lot of questions have been left unanswered by the legislation.
 4. Comments were accepted on the proposed rule until June 30, 2006. A final rule is expected sometime in late Fall 2006.
 5. During 2006, CMS will need to award implementation contracts, continue with the educational programs for beneficiaries, suppliers, and referral sources, implement appropriate systems changes and conduct supplier bidding.
 6. Section 302 of the MMA also requires the establishment of quality standards and an accreditation rule.
 - a. Accreditation Rule. CMS issued a final rule on August 1, 2006, that establishes requirements for accreditation of DME suppliers and lays the groundwork for implementation of competitive bidding. This rule details the application process for accrediting organizations that would apply quality standards for all DME suppliers including those that would participate in competitive bidding. According to CMS, it desires to minimize burden and duplication of effort for suppliers that have already been accredited, Medicare-certified, and/or licensed under state law, by taking into consideration any previous accreditation, certification, and/or licensure findings that indicate that quality standards are being met at the time the accreditation organization surveys the

supplier. CMS does not have the statutory authority to exempt any supplier that furnishes DME, prosthetic devices, prosthetics, and/or orthotics under Part B from meeting the quality standards and accreditation requirements. CMS is phasing-in the requirement for DME suppliers to become accredited consistent with the statutory phase-in of the Competitive Bidding Program. Thus, those suppliers in the first phase of competitive bidding will need to be accredited in early 2007. Those in the second phase will need to be accredited by the winter of 2007. The statute does not establish further dates for implementation; CMS will provide future guidance as to the date by which all suppliers need to be accredited. CMS is requesting accreditation organizations to prioritize their surveys based on the statutory requirements for phasing-in implementation of the Competitive Bidding Program. The first priority will be to accredit suppliers in the MSAs for 2007. CMS expects to approve several accreditation organizations in order to meet the bidding dates.

According to CMS, it recognizes that becoming accredited imposes a burden on suppliers and has attempted to minimize the burden by taking the following actions:

- 1) Accreditation organization selection – CMS expects to select several accreditation organizations, which will presumably induce competition and assist in decreasing accreditation costs.
- 2) Plan for small business – During the application process, CMS will ask accreditation organizations to include a plan that outlines their methodology to reduce accreditation fees for small/specialty suppliers and suppliers that have multiple locations.
- 3) Application of streamlined quality standards – CMS will encourage accreditation organizations not to expand on streamlined quality standards.
- 4) Streamlined processes – CMS has clarified in the final rule that the role of the accreditation organizations is to ensure compliance with the quality standards and that accreditation should not be contingent on using consultation services or purchasing manuals.

- 5) Unannounced survey process – Utilizing an unannounced survey process reduces “ramp-up” costs and survey preparation time.

b. Quality Standards.

- 1) On August 15, 2006, CMS released the long-awaited quality standards for DME suppliers. These standards are released in final form with no additional opportunity for public comment. Suppliers must meet these new quality standards in order to furnish any DME item for which Medicare Part B makes payment as well as to receive or retain a provider or supplier billing number used to submit claims for reimbursement for any item or service for which payment can be made by Medicare.

- 2) Based on more than 5,600 comments received on the September 2005 draft quality standards, CMS has made revisions to the final quality standards. According to CMS, examples of key revisions include:

- Eliminating unnecessary specificity and redundant information and reduced the standards from 104 pages to 14 pages.
- Modifying overly-prescriptive requirements to focus more clearly on providing reliable quality service to beneficiaries (for example, eliminating the requirement to be open for 40 hours per week and replacing it with a requirement to maintain posted business hours).
- Clarifying requirements for performance management to allow suppliers flexibility in determining indicators related to their products and services.
- Consolidating and incorporating certain product-specific standards into the general product-specific service standards, reducing the number of product specific standards from 15 to 3.

7. Competitive Bidding Implementation Contractors. The MMA specifies that the Secretary may contract with appropriate entities to implement the

Competitive Bidding Program. It is the intention of CMS to contract with one or more Competitive Bidding Implementation Contractors (“CBICs”) to assist it with various tasks. There are a number of functions for which the CBIC will be responsible:

- Overall oversight and decision making;
- Operation design functions;
- Bidding and evaluation;
- Access and quality monitoring;
- Outreach and education; and
- Claims processing.

Medicare Administrative Contractors (“MACs”) will continue to process claims and perform other MAC functions. For example, MACs will continue to be responsible for outreach and education to beneficiaries and suppliers; processing claims and applying the single payment amount; and responding to complaints related to claims processing. The CBIC will perform certain functions at a national level, such as implementing the request for bids (“RFBs”); conducting bid evaluations; selecting qualified suppliers; and setting single payment amounts for all competitive bid areas. The CBIC will also be responsible for educating the MACs on the bidding process and assisting the MACs in monitoring program effectiveness, access and quality.

8. Education and Outreach Campaign Beneficiary Education. CMS expects to conduct an education campaign to ensure that Medicare beneficiaries receive information about the Competitive Bidding Program. CMS expects to use resources such as 1-800-MEDICARE, www.medicare.gov, and other beneficiary-centered communications (e.g., publications, brochures, direct mail) and promote these information resources to educate consumers about Competitive Bidding.
9. Supplier Education. CMS is planning an education campaign, including special bidders conferences, to provide information about the bidding process and to ensure that DME suppliers are aware of all aspects of the Competitive Bidding Program. CMS will also provide education to ensure that referral sources and staff who work for them are prepared to refer people with Medicare to DME contract suppliers.

10. Payment Basis. Payment will be based on the “single payment amount” for the item in the area where the beneficiary maintains a permanent residence. The use of ABNs will not be precluded for items that might not be covered by Medicare.
11. Grandfathering Suppliers. There will be a “grandfathering” process by which rental agreements for covered items and supply arrangements with oxygen suppliers entered into before the start of a competitive bidding program may be continued. This would only apply to those suppliers that began furnishing the item prior to implementation of the program. Beneficiaries will have the ability to decide whether they would like to continue renting the item from the grandfathered supplier or a contract supplier provided the grandfathered supplier is willing to continue furnishing the item under the same terms as the contract supplier. If a supplier chooses to be a grandfathered supplier, then it must do so for all beneficiaries who request the services. The grandfathered supplier will receive the competitive bid payment amount for oxygen and items requiring frequent and substantial servicing. Grandfathering will also apply to suppliers that lose their contract status in a subsequent competitive bidding program.
12. Traveling Beneficiaries. Beneficiaries traveling from one competitive bid area to another will be required to obtain items from another contract supplier. Beneficiaries traveling from a competitive bid area to a non-competitive bid area will only be required to obtain items from a supplier with a valid supplier number. Payment will be based on the single payment amount for the item in the area where the beneficiary maintains his/her permanent residence.

III. THE HOBSON-TANNER BILL

- A. Rep. David Hobson (R-Ohio) and Rep. John Tanner (D-Tenn) introduced a bill known as the Hobson-Tanner Bill (“Bill”) that would amend several provisions of the MMA dealing with competitive bidding.
- B. The Bill would not repeal competitive bidding.
- C. The goal of the Bill is to protect patient access and to ensure that small suppliers can participate in the bidding process.
- D. The bill would allow qualified small suppliers, that submit a bid below the current allowable, to participate at the selected award price.

- E. Under the MMA, CMS can extend the reimbursement established under competitive bidding to non-competitive bid areas. However, before extending reimbursement to non-competitive bid areas, the Bill would require CMS to conduct a comparability analysis for those areas to ensure the rate is appropriate to cost and does not reduce access to care.
- F. The Bill also includes provisions that:
 - 1. Would restore judicial or administrative review of a number of CMS decisions related to competitive bidding.
 - 2. Would require the quality standards to be in place before competitive bidding is implemented.
 - 3. Would exempt small rural (populations under 500,000) MSAs.
 - a. Would exempt items and services unless a 10% savings could be demonstrated.
 - b. Would subject the Program Advisory and Oversight Committee to the Federal Advisory Committee Act which requires public access to meetings and proceedings.

IV. PROPOSED RULES

- A. On April 24, 2006, CMS released a proposed regulation on implementation of the DME competitive bidding program that is scheduled to begin in 2007.
- B. The proposed regulation does not give definite answers to the most pressing questions about the program.
- C. Implementation Date

CMS intends to make the competitive bidding payment methodology effective on October 1, 2007, rather than January 1, 2007, as announced previously.
- D. Metropolitan Statistical Areas
 - 1. The proposed regulation does not state which 10 MSAs will be the sites for the initial round of competitive bidding.
 - 2. It provides some information about how those MSAs will be chosen.

- a. CMS proposes to begin with a list of the 50 largest MSAs based on total 2005 population.
 - b. From these 50, CMS will select the 25 that had the largest total allowed Medicare charges for DMEPOS in calendar year 2004.
 - c. Those 25 MSAs will be ranked according to two criteria: allowed DMEPOS charges per beneficiary, and the number of DMEPOS suppliers per beneficiary receiving DMEPOS items.
 - d. From the ranked list, CMS will exclude the three largest MSAs: New York, Los Angeles and Chicago.
 - e. Also excluded will be any MSA that crosses DMERC boundaries.
 - f. From the remaining MSAs, CMS will select the highest-scoring MSA in each DMERC region, and the next six highest regardless of region, but not more than two from any one state.
3. In the regulation's preamble, CMS provides illustrations of its selection process using data from 2003. The 2004 and 2005 data will not be identical to the 2003 data, but there will probably not be dramatic changes. Therefore, it is possible to make some educated guesses about the MSAs that are likely to be or not to be chosen.
 4. CMS has already decided that New York, Chicago and Los Angeles will be excluded from the 2007 list. Suppliers in the Philadelphia, St. Louis and Virginia Beach MSAs can also breathe easier for the time being. Those MSAs will be excluded because they cross DMERC boundaries. (The Cincinnati MSA presently crosses a DMERC boundary, but it will be entirely within Region B after Kentucky joins Region B on July 1, 2006.)
 5. The announced methodology makes it almost inevitable that either Miami or Houston will be the highest-ranked MSA in Region C, and that the other of those two will also be included in the 2007 round of competitive bidding. Dallas is also a likely candidate, but San Antonio could possibly move above Dallas in the rankings. In that case, Dallas would be excluded because of the rule that no more than two MSAs may be selected from a single state.
 6. The highest-ranking MSAs in the other three regions, based on the 2003 data, are Pittsburgh in Region A, Cincinnati in Region B, and Riverside/San Bernardino/Ontario in Region D. Pittsburgh's ranking is unlikely to change, because the next two highest-rated MSAs in the

region, Philadelphia and New York, are both excluded. Riverside's ranking is also unlikely to change. However, Cincinnati could be replaced in Region B by either Cleveland or Detroit.

7. Continuing with the selection methodology using the 2003 data, seven of the ten MSAs that would be selected – all but the three representatives of the other regions – would be from Region C. Those seven would be Miami, Houston, Dallas, Charlotte, Orlando, San Juan and Atlanta. It is possible that CMS will modify the selection criteria to avoid this extreme concentration in Region C. In that case, Kansas City, San Francisco, Cleveland and Detroit would be possible candidates for selection.

E. Product Categories

1. The MMA authorizes CMS to phase in competitive bidding beginning with the “highest cost and highest volume items or those items that the Secretary determines have the largest savings potential.”
2. CMS intends to conduct the bidding process using products grouped into categories.
3. The categories to be included in the 2007 round of bidding will be chosen based on statistics for “policy groups” defined by the Statistical Analysis DMERC (“SADMERC”), but the specific products that will be included in the bidding program may not exactly correspond to the policy groups.
4. CMS says that its selection of products for competitive bidding will be based on annual Medicare DMEPOS allowed charges, annual growth in expenditures, number of suppliers (because CMS believes that a larger number of suppliers means more competition), savings in the DMEPOS demonstrations, and reports and studies. The highest priority will be given to items with high allowed charges or rapidly increasing allowed charges.
5. A small number of product categories account for a large percentage of Medicare DMEPOS allowed charges. In 2003, the products in just four SADMERC policy groups accounted for more than 50% of total expenditures. These categories were:
 - a. Oxygen supplies and equipment;
 - b. Wheelchairs and POVs;
 - c. Diabetic supplies and equipment; and

- d. Enteral nutrition.
6. The rest of the top 10 policy groups in 2003 were:
 - a. Hospital beds and accessories;
 - b. CPAP devices;
 - c. Support surfaces;
 - d. Infusion pumps and related drugs; and
 - e. Respiratory assist devices and lower limb orthoses.
7. Not all of these items will be included in the first round of competitive bidding, but most of the included products will come from these categories.
8. CMS suggests in the preamble that breast prostheses and dialysis equipment and supplies may also be included.

F. Selection of Suppliers

1. Suppliers will submit bids on individual products in a product category, CMS will calculate a weighted composite bid for each bidder from the individual product bids, and will award contracts based on the composite bids.
2. CMS proposes to decide the number of suppliers selected for each product category based on expected demand and supplier capacity.
3. The number of winning bidders for a category will be the minimum number of suppliers that together have the capacity to meet the expected demand for products in that category.

G. Rebates

1. CMS proposes to set a single price for each item in each area, equal to the median of the bid prices of the winning bidders.
2. CMS has added a provision by providing that those suppliers that submitted bids below the final price will be permitted to give rebates to

beneficiaries equal to the difference between the bid and the payment amount.

3. Providing rebates will be voluntary, but suppliers may not offer them on a case-by-case basis.
4. If a supplier elects to offer a rebate on an item, it must offer the rebate to all beneficiaries receiving the item.
5. Only those bidders whose bids are lower than the final allowable amount will be permitted to offer rebates.
6. CMS proposes to prohibit suppliers from advertising rebates, but says that the agency may provide information to beneficiaries about the suppliers that offer rebates.

H. Accreditation

The proposed rule does not give much new information about the accreditation process for DMEPOS suppliers. It does say that suppliers that are not yet accredited will not necessarily be barred from participating in the competitive bidding process. There may be a grace period for suppliers that do not have time to become accredited before bids are due. CMS also says that if a supplier is already accredited by one of the accreditation organizations designated by CMS, it will be grandfathered for one accreditation cycle.

V. PAST COMPETITIVE BIDDING DEMONSTRATIONS

A. Background of Florida Demonstration Projects

1. With the goal of improving the efficiency of the Medicare Program, the Balanced Budget Act of 1997 (“BBA”) authorized CMS to test competitive bidding as a way for Medicare to price and pay for some categories of items and services.
2. Several studies showed that the Medicare program and Medicare beneficiaries have been paying too much for some medical equipment and supplies.
3. In 1997, approximately \$6 billion was spent on equipment and supplies under the Medicare program.

4. According to CMS, competitive bidding is intended to use the dynamics of the marketplace to provide incentives for suppliers to provide items and services in an efficient manner.
5. CMS sees competitive bidding as a way to reduce Medicare fraud and abuse by screening out suppliers that do not operate with ethical business practices.
6. Section 1847 of the Social Security Act authorized the Secretary to conduct Demonstration Projects.
7. In these projects, Medicare Part B items and services (other than physician services) are furnished under competitively awarded contracts, with competitions conducted in competitive acquisition areas (defined under the act as an MSA or smaller area within an MSA).
8. Under this authority, CMS implemented competitive bidding for DME in two demonstration sites from 1999 to 2002.
9. The approach of CMS was to test competitive bidding in the context of the current regulatory environment, without otherwise making major changes.
10. In the first site, Polk County, Florida, (pop. 491,851) CMS conducted the first of two rounds of bidding in 1999.
11. Five categories of DME were put up for bidding:
 - a. oxygen equipment and supplies (required by statute);
 - b. hospital beds and accessories;
 - c. enteral nutrition formulas and equipment;
 - d. urological supplies; and
 - e. surgical dressings.
12. A total of 16 winning suppliers began providing demonstration products and services in Polk County on October 1, 1999, and continued for two years.
13. The second and final round of bidding in Polk County was conducted in 2001 for the same product categories minus enteral nutrition.

14. Enteral nutrition was dropped to retain only product categories that are overwhelmingly used in private homes.
15. The second set of competitively bid fees took effect in October 2001.
16. As in round one, 16 suppliers were selected, of whom half participated as winners previously.
17. The new fee schedules developed from the bids in each round replaced the statewide Medicare DMEPOS fees.
18. The second round of the demonstration in Polk County ended in September 2002.

B. Background of Texas Demonstration Project

1. In the San Antonio MSA's Bexar, Comal, and Guadalupe counties (pop. 1,593,389) CMS conducted bidding in 2000 for five kinds of DMEPOS:
 - a. oxygen equipment and supplies;
 - b. hospital beds and accessories;
 - c. wheelchairs and accessories;
 - d. general orthotics;
 - e. and nebulizer drugs.
2. 51 suppliers were selected and began serving Medicare beneficiaries under the new fees in February 2001.
3. The San Antonio demonstration ended in December 2002, the statutorily required termination date in the BBA.

C. Evaluation Study

1. CMS contracted with the University of Wisconsin-Madison in 1998 to conduct the evaluation.
2. The University and the Research Triangle Institute ("RTI") led the evaluation team.
3. For the First Annual Report, evaluation activities included:

- a. a beneficiary survey;
 - b. five site visits by the team to Polk County, Florida, and to the Medicare DMERC managing the project in 1999 and 2000 (Palmetto Government Benefits Administrators [PGBA]);
 - c. focus groups in Polk County with suppliers and members of other affected groups;
 - d. analysis of suppliers' bids and comparison of fee schedules; and
 - e. review of operational and documentary materials such as ombudsman records and the demonstration Request for Bid Proposals from suppliers.
4. For the Second Annual Report, the team conducted a follow-up beneficiary survey in Polk County, enabling assessment of numerous effects of competitive bidding.
 5. The team also analyzed the Medicare savings under the second competitively bid fee schedule in Polk County and collected information from nine Florida suppliers in a written format.
 6. The team traveled to San Antonio for three site visits to interview demonstration and nondemonstration suppliers, referral agents, beneficiary representatives, and the San Antonio demonstration ombudsman.
 7. The team analyzed Medicare savings under the competitively bid fee schedule in San Antonio.
 8. The team held discussions about the San Antonio operations with PGBA.
 9. As in Polk County, a baseline survey was administered to a sample of Texas beneficiaries.
 10. Additional evaluation activities followed the Second Annual Report.
 11. The team conducted a follow-up survey among San Antonio beneficiaries to enable comparisons with the base line survey.
 12. The team conducted several analyses of Medicare claims data from 1997 to 2002 in order to refine earlier estimates of Medicare savings under the

demonstration, examine access to portable oxygen, assess competition in the demonstration areas, and test for possible volume changes due to the demonstration.

13. A supplier survey in San Antonio and a comparison area was fielded to study impacts on product selection and on the financial status of suppliers.
14. The team also conducted one additional site visit to Polk County and one to San Antonio, during which it gathered information from informants and stakeholders such as referral agents, suppliers, and beneficiary groups.
15. From these many sources, the evaluation team developed a wide array of information to disseminate to both policymakers and Medicare program planners.

D. Results

1. In each area, evaluation data indicate mostly favorable results for the Medicare program.
2. The project saved significant expenditures, nearly 20 percent overall in each site.
3. Statistical and qualitative data indicate that beneficiary access and quality of services were essentially unchanged.
4. With the help of traditional intermediaries such as hospital discharge planners and physicians, beneficiaries negotiated the new system satisfactorily.
5. A few areas of concern surfaced in either statistical data or site visits—most notably, possible pressure on access to portable oxygen in Polk County, where evidence from both the beneficiary survey and person-level claims analysis indicated a reduction in the proportion of oxygen patients using portable oxygen.
6. An area of concern arising during San Antonio site visits was reportedly poor service quality from some wheelchair suppliers.
7. Some of the specific concerns involved improper fitting and instances of separate billing for accessories formerly provided gratis as part of the overall wheelchair order.

8. Although it was difficult to generate information on changes in product selection, the San Antonio supplier survey and site visit data suggest that beneficiaries experienced little or no change in the array of products available to them.
9. The market competitiveness analysis indicated that adequate numbers of bidders participated, particularly in the larger-volume product categories.
10. A second competition held in Polk County after two years resulted in 50 percent turnover in winning suppliers;
11. Both small and large suppliers were selected.
12. Market concentration usually changed little, despite the fact that 53 percent to 65 percent of bidders were chosen as suppliers.
13. CMS, with PGBA serving as project manager, successfully administered the new payment system, from early site preparation through the bid solicitation and evaluation period, to the implementation and monitoring phases.
14. Suppliers reported little difficulty preparing bids, and claims processing proceeded smoothly.
15. Medicare's policy objectives in terms of savings, access, quality, competition, and administrative feasibility were largely realized under the competitive bidding demonstration.
16. The program design, calling for multiple winners to maintain quality-based competition, appeared to be a critical element.
17. For example, during site visits, referral agents repeatedly took credit for judging service quality and steering beneficiaries to suppliers whom they judged to be the better performers.
18. For the dual purposes of maintaining quality and access, and sustaining competitive markets, the multiple winner design appeared to serve Medicare's needs.
19. Medicare Expenditures
 - a. Fee schedules resulting from the three bidding competitions held in the two sites suggest that substantial savings can be realized from competitive bidding.

- b. Final estimates suggest savings of 16-17 percent annually in Polk County's Round 1, 20 percent in Polk County's Round 2, and 20 percent in San Antonio's single round.
- c. Overall, the demonstration in both sites saved 19 percent over what would have been paid under the existing statutory fees.
- d. The demonstration reduced Medicare payments by \$7.5 million and beneficiary payments by \$1.9 million.

20. Access to DMEPOS Goods and Services

- a. The evaluation's three main sources of information on access to care were the beneficiary surveys, site visits, and San Antonio supplier survey.
- b. Data from all three sources suggested little or no impact of the demonstration on access to goods and services put up for bidding.
- c. Reduced use of portable oxygen among Polk County beneficiaries is the single important result pointing to a risk of lower access under competitive bidding.
- d. In both sites, transition policies protected beneficiaries from disruptions in existing relationships with oxygen companies, nebulizer drug suppliers, and suppliers of capped rental equipment (nutrition infusion pumps, hospital beds, and wheelchairs).
- e. For oxygen and nebulizer drugs, existing relationships could continue as long as the supplier agreed to accept demonstration fees, and suppliers overwhelmingly agreed to this arrangement.
- f. Capped rental fees for agreements predating the demonstration stayed in place.
- g. New users are more likely to be directly affected by the demonstration, because they had no previous relationship with a supplier in their product category.
- h. New users accounted for 10 to 40 percent of the samples (across sites and time periods).

- i. Questionnaires covered a wide range of measures dealing with access to equipment, training, maintenance, customer service, and delivery services.
- j. Responses collected before the demonstration were compared with responses after the demonstration.
- k. Impact estimates took into account general trends that might affect responses (by surveying a similar area).
- l. Estimates also controlled for sample differences in demographic composition and health status.

21. Quality and Product Selection

- a. The evaluation's three main sources of information on quality and product selection were the beneficiary surveys, site visits, and the San Antonio supplier survey.
- b. Global measures of beneficiaries' satisfaction with their supplier remained high under the demonstration, and detailed quality measures were similarly favorable and stable.
- c. Based on the supplier survey, products provided to beneficiaries changed little during the demonstration.
- d. The site visits revealed issues surrounding urological supplies and wheelchair fitting and delivery.

22. Market Competitiveness

- a. Evidence for evaluating impacts on market competitiveness came from four sources:
 - 1) bidder participation and selection data, particularly from the two rounds of bidding conducted in Polk County;
 - 2) claims analysis of changes in Medicare market shares;
 - 3) site visit informants; and
 - 4) the San Antonio supplier survey.

- b. For the Final Evaluation Report, the evaluation team undertook extensive claims analysis to track market share changes between demonstration and nondemonstration suppliers, to measure market concentration, and to trace individual market shares of participating firms.
- c. The analyses suggested that during the three year period of the project, the DME markets for the demonstration product lines tended to stay close to their former concentration levels, even while demonstration suppliers as a group gained market share.
- d. Several other pieces of evidence pointed to good signs for competitiveness.
- e. For example, most product categories attracted numerous bidders, firms that submitted bids had a good chance of being selected, and although suppliers have a strong tendency to dislike competitive bidding, there was still some opinion among them that the demonstration-related markets remained competitive.

23. Administrative Feasibility of the Reimbursement System

- a. The evaluation of administrative feasibility addressed the ease of implementing the process of competitive bidding and of administering the post-bidding phases, including the transition to approved suppliers, new reimbursement procedures, and site monitoring.
- b. The evaluation team also considered the net savings from the competitive bidding project after accounting for estimated administrative costs.
- c. The team further estimated costs under a national program using the same administrative structure used in the demonstration.
- d. Estimates suggested favorable returns from competitive bidding--especially favorable under an extension to additional competitive bidding areas.
- e. Extrapolating administrative costs to a national program and assuming conservative savings, the team illustrated that investing in a national program might bring savings twice as large as outlays.

24. Implementation and Operations

- a. CMS essentially replicated the same competitive bidding model in Polk County and San Antonio.
- b. Substantial early efforts to educate beneficiaries, referral agents, and suppliers about the demonstration helped to ease the transition to the competitively bid fees and approved suppliers list.
- c. Transition policies helped beneficiaries and providers adjust.
- d. Experience also improved the weighting formula for summarizing bid prices into a summary bid.
- e. The ombudsman conducted in-person information sessions about the demonstration, responded to inquiries about the demonstration from all stakeholders, coordinated bid evaluation site visits to suppliers, and generally served as Medicare’s “eyes and ears” on-site.
- f. PGBA encountered few problems in automated processing of claims for the demonstration areas. Because several ZIP Codes in Texas crossed into nondemonstration counties, claims from these areas had to be pulled from the claims stream and manually processed, but this affected relatively few claims.
- g. A delay in issuing the San Antonio directory of approved suppliers appeared to cause avoidable difficulties in making DME arrangements for some beneficiaries early in the transition.
- h. In both sites, informants recommended earlier release of the directory.
- i. This underscores the importance of allowing sufficient time for site stakeholders to prepare for each changeover to new approved suppliers.

25. Demonstration Savings Net of Costs

- a. Costs of administering the demonstration projects were estimated to be \$4.8 million (in year 2000 dollars).
- b. These costs covered research and development activities begun in 1995, subsequent public and supplier education, bidding and bid

evaluation, modifications to claims processing, and ongoing site monitoring until project termination in December 2002.

- c. Total estimated savings in the two demonstration sites since October 1999 through termination were \$9.4 million.
- d. \$7.5 million are Medicare savings.
- e. \$1.9 million are beneficiary savings.
- f. This implies net savings to the Medicare program of \$2.7 million.
- g. Spreading the large fixed-cost component of the project over additional sites would likely increase the return substantially.
- h. For example, the cost of adding the San Antonio site was \$310,000 in the first full year, during which bidding was conducted.
- i. When bidding was not conducted, the annual costs were about \$100,000.
- j. Over three years (2000 to 2002) the San Antonio site cost \$510,000 to run versus estimated savings of approximately \$4.6 million.
- k. The actual net savings from adding more sites would depend on factors such as the size and competitiveness of the market in the additional sites, and the particulars of bidding design and administration.

VI. CMS' CONCLUSIONS RESULTING FROM THE COMPETITIVE BID PROJECTS

- A. The broad variety of data used to evaluate the DMEPOS competitive bidding demonstration suggested that the tests in Polk County and San Antonio largely met Medicare's objectives in terms of program savings; maintaining access, quality, and product selection; preserving competition; and administrative feasibility.
- B. Savings estimates were about one-fifth relative to payments under the statutory

- D. CMS demonstrated a workable competitive bidding design and feasible operating procedures and policies.
- E. This does not assume that some suppliers' behavior remained completely the same.
- F. It is logical to think that cost-saving measures will be pursued when prices fall.
- G. Policy makers are interested in whether any behavioral changes to reduce costs were counterproductive for beneficiaries and the Medicare program, or whether they represented efficiency improvements.
- H. Further, policy makers are interested in whether any new value was added to the services (some of which may be cost-increasing).
- I. The evaluation revealed examples of value added to beneficiaries' services:
 - 1. improved product reliability;
 - 2. easier telephone access to suppliers;
 - 3. more attention to insurance procedures at the start of the beneficiary/supplier relationship; and
 - 4. higher frequency of portable oxygen refills.
- J. Given the controversy surrounding competitive bidding, cost-saving behaviors attract more attention.
- K. The evaluation study provided possible examples of these, too.
- L. Examples affecting subgroups of beneficiaries included:
 - 1. more provision of used vs. new mattresses to hospital bed users; more use of mail delivery and less use of home delivery; and possibly
 - 2. separate billing for wheelchair accessories previously informally bundled into the wheelchair fee.
- M. Examples affecting subgroups of beneficiaries included:
 - 1. fewer excess supplies; fewer maintenance visits;

2. more use of oxygen conserving devices on portable oxygen equipment; and
 3. less provision of portable oxygen.
- N. Some examples may be seen as a benefit by beneficiaries (e.g., oxygen-conserving devices simplifying logistics of travel outside the home).
- O. The shifts do not appear harmful or pervasive enough to be a concern, and some observers may consider specific changes justifiable from an efficiency standpoint.
- P. A risk of lower access to portable oxygen is probably the biggest concern raised by the evaluation results.
- Q. Equally, the evidence on portable oxygen highlights the problem of how the Medicare program can achieve an appropriate and efficient allocation of portable oxygen to beneficiaries who need it and will use it, under either competitive bidding or current payment methods.
- R. Policy tools such as stakeholder education, improvements in data, and revisions to payment procedures may all have a role to play in meeting this challenge.

VII. STEPS TO INCREASE THE CHANCE OF BEING A SUCCESSFUL BIDDER

- A. The supplier must understand its operation. Realistically, what products can the supplier provide and what geographical area can the supplier cover? What direct and indirect costs does the supplier have in its products? How efficient is the supplier's operation? Is the supplier "lean and mean" or does it have too many employees? Does the supplier understand its cost structure (both direct and indirect costs)? If the supplier is a successful bidder, will it be able to increase its market share?
- B. Steps Preparatory to Submission of Bid
1. Is the supplier located in a probable competitive bid area?
 2. The supplier needs to understand the bid selection process and criteria.
 3. The supplier needs to understand the product and service requirements.
 4. The supplier must be accredited.
 5. The supplier needs to pick the products it can provide.

6. Realistically, what percent of the market (for a particular product) can the supplier handle?
7. The supplier must understand its “numbers” (financial and operation data). In so doing, it would be wise for the supplier to use spreadsheet tools.
8. The supplier needs to develop a bid for each HCPCS code.
9. Reality check – How much of a discount (off its usual and customary charge) will the supplier give? Are the supplier’s projected costs achievable? Does the supplier have any cushion...that is, any margin for error?
10. The supplier needs to gather bid package forms and information.
 - a. Form A (Application) requires the bidding supplier to provide general information about the characteristics of its company, including accreditation information, product categories being bid, bank references, credit bureau report, key personnel, and financial statements.
 - b. Form B (Bidding Sheet) requires the bidding supplier to provide specific information about the prices it bids for specific product items and other information, including total revenue for the past year for the product categories for which the supplier is submitting a bid, total customers served for each product category, expansion plans, and subcontractors that the supplier will use.
 - c. Form C (Bank Reference) requires the Competitive Bid Implementation Contractor (“CBIC”) to review the supplier’s financial standing. The supplier completes a portion and sends the document to the bank for completion and execution. The bank then sends the completed form to the CBIC.
 - d. Form D (Quarterly Report) will be used by the CBIC to ensure that Medicare beneficiaries have access to competitive bid items with specific features.
 - e. Form E (Beneficiary Survey) will be used by the CBIC and CMS to determine the quality of service that beneficiaries receive from contract suppliers.

These written materials are not intended to be legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only. The law pertaining to the issues addressed by these written materials may have changed since these written materials were submitted. The reader should consult his or her own attorney for legal advice. Except where noted, attorneys are not certified by the Texas Board of Legal Specialization.

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Learning Assessment Questions

Presentation Title: Turning a Challenge Into an Opportunity: How to Succeed with Competitive Bidding

Name of Presenter: Jeffrey S. Baird, Esq. and Denise M. Fletcher, Esq.

1. If a supplier is not awarded a bid contract, under a “grandfathering” process it may continue to service oxygen concentrators placed with patients prior to implementation of the competitive bid program.
2. A beneficiary traveling from one competitive bid area to another competitive bid area will be required to obtain items from a contract supplier located in the area to which the beneficiary travels.
3. The Hobson-Tanner Bill, if passed, will repeal competitive bidding.
4. Competitive bidding is to begin on January 1, 2007.
5. The number of winning bidders for a product category will be the number of suppliers that, together, have the capacity to meet the expected demand for products in that category.

Learning Assessment Questions

Presentation Title: Turning a Challenge Into an Opportunity: How to Succeed with Competitive Bidding

Name of Presenter: Jeffrey S. Baird, Esq. and Denise M. Fletcher, Esq.

Answers:

1. True
2. True
3. False
4. False
5. True