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RANKING MEMBER

Congress of the United States

U.S. House of Representatives

Committee on Small Business

2361 Rayburn House Office Building
Washington, DC 20515-6315

MEMORANDUM

TO:	Members, Subcommittee on Healthcare and Technology, House Committee on Small Business
FROM:	Staff, House Committee on Small Business
DATE:	September 10, 2012
RE:	Hearing: Medicare's Durable Medical Equipment Competitive Bidding Program: How Are Small Suppliers Faring?"

This memorandum will summarize the history and current status of the Medicare competitive bidding program for durable medical equipment and prosthetics, orthotics and related supplies (DMEPOS). In particular, the memorandum will distinguish between government-set reimbursement rates for DMEPOS using a fee schedule and market-based competitive bidding for the same items. The competitive bidding program has been in effect since 1999, and is gradually being implemented nationwide. The purpose of this hearing is to examine the program's impact on small businesses that offer DMEPOS supplies.

I. Background on the DMEPOS Program

Medicare is a nationwide health insurance program established in 1965 for the aged and disabled.[1] DMEPOS are covered under Part B, a voluntary program (in which most beneficiaries participate upon the payment of premiums). Eligible beneficiaries may obtain DMEPOS under Part B if they are prescribed by a licensed physician and medically or physically necessary.[2] Durable medical equipment (DME) is equipment that: 1) can withstand repeated use; 2) is used to serve a medical purpose; 3) generally is not useful in the absence of illness or injury; and 4) is appropriate for use in the home.[3]

Beginning in 1987, the Omnibus Budget Control Act[4] (OBRA) implemented a fee schedule system of payment for most DMEPOS devices provided after January 1, 1989.[5] Specifically, the Medicare payment for these items is equal to 80 percent of the lesser of the actual charge for the

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[1] 42 U.S.C. § 1395-1395kkk-1.
[2] 42 U.S.C. § 1395(j).
[3] 42 U.S.C. § 1395x(m).
[4] 42 U.S.C. § 1395x(n); 42 C.F.R. § 410.38.
[5] 42 U.S.C. § 1834(a)(1)(A) and (B) and § 1834(h)(1)(A).

item or the fee schedule amount for the item.[6] Fee schedules are updated each year using the Consumer Price Index for All Urban Consumers.[7] Medicare's fee schedule classifies most DMEPOS items into six payment categories, from low to high cost. Depending on the category, Medicare payments may be a lump sum or continuing payments over time, such as a monthly payment, and sometimes include payments for the maintenance or repair of a product or both. To obtain payment, suppliers use a coding system that identifies the category of items supplied (such as wheelchairs) rather than a specific brand name's product. CMS contracts with administrative processors to handle Medicare payments.

Medicare beneficiaries usually obtain their DMEPOS products directly from suppliers. The supplier submits a claim to Medicare for the beneficiary, and the suppliers obtain products from manufacturers or other distributors. Because suppliers may keep the difference between the negotiated price and the Medicare payment, there is an incentive to negotiate a low price. Prior to 1997, any qualified company was permitted to become a DMEPOS supplier.

In 1995, Congress began to consider competitive bidding as a way to reduce escalating Medicare costs.[8] As a result, Congress enacted legislation in 1997 requiring Medicare to institute a competitive bidding program. Multiple reports by the Government Accountability Office (GAO)[9] and the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS)[10] since 1997 on the fee schedule payment system have found that

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[6] 42 U.S.C. 1834(h)(1)(a).

[7] CONSUMER PRICE INDEX, BUREAU OF LABOR STATISTICS, U.S. DEPARTMENT OF LABOR, *available at* ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt.

[8] *See, e.g., Waste Fraud and Abuse in the Medicare Program: Joint Hearing Before the Subcommittee on Health and Environment and the Subcommittee on Oversight and Investigations of the Committee on Commerce*, U.S. House of Representatives (May 16, 1995); REPORT TO THE CHAIRMAN, HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE, COMMITTEE ON GOVERNMENTAL REFORM AND OVERSIGHT, U.S. HOUSE OF REPRESENTATIVES, MEDICARE SPENDING: MODERN MANAGEMENT STRATEGIES NEEDED TO CURB BILLIONS IN UNNECESSARY PAYMENTS (SEPTEMBER 1995) (GAO/HEHS 95-10), *available at* http://www.gao.gov/assets/230/221716.pdf; Letter from Jonathan Ratner, Associate Director, Health Financing Issues to Joe Barton, Chairman, Subcommittee on Oversight and Investigations, House Committee on Commerce (August 11, 1995), *available at* http://www.gao.gov/assets/90/84989.pdf; Letter from William J. Scanlon, Director, Health Financing and Systems Issues, GAO, to John Breaux, Ranking Minority Member, Senate Committee on Aging (June 12, 1997) (GAO/HEHS 98-29), *available at* http://archive.gao.gov/paprpdf1/158828.pdf.

[9] *See, e.g.,* GAO, *Medicare Payments for Oxygen*, May 15, 1997 (GAO-97-120R); *Medicare: Competitive Bidding of Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical: Hearing Before the Committee on Ways and Means Subcommittee on Health, U.S. House of Representatives* (May 6, 2008) *and* (testimony of Kathleen M. King, Director, Health Care, U.S. Government Accountability Office), *available at* http://www.gao.gov/assets/100/97606.pdf; U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICARE HOME OXYGEN: REFINING PAYMENT METHODOLOGY HAS POTENTIAL TO LOWER PROGRAM AND BENEFICIARY SPENDING (JANUARY 2011) (GAO-11-56), *available at http://www.gao.gov/new.items/d1156.pdf.*

[10] *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, MEDICARE HOME OXYGEN EQUIPMENT: COST AND SERVICING (March 2005) (EOI-09-04-00420), *available at* http://oig.hhs.gov/oei/reports/oei-09-04-00420.pdf; *Hearing Before the U.S. Senate Subcommittee on Labor, Health and Human Services and Education, Committee on Appropriations* (June 12, 2001) (testimony of the Inspector General, U.S. Department of Health and Human Services) *available at* http://oig.hhs.gov/testimony/docs/2002/020611fin.pdf; and U.S. DEPARTMENT OF HEALTH AND HUMAN

Medicare pays above-market prices for certain DME items. In addition, the benefit was plagued by a payment error rate of 61%.[11]

II. DMEPOS Competitive Bidding Program (CBP)

A. The Balanced Budget Act of 1997

The Balanced Budget Act of 1997[12] (BBA) required CMS to test competitive bidding for DMEPOS and other medical supplies and services as listed in § 1861(s) of the Social Security Act[13] for determining reimbursement under Part B of Medicare. The goal of the competitive bidding test was to evaluate the impact of establishing competitive acquisition areas on Medicare program savings, access, diversity of product selection and quality.[14] Under the program, the Secretary of Health and Human Services was required to consult with an advisory task force of providers and suppliers, including small business providers and suppliers.[15]

The BBA authorized up to five demonstration projects, of which at least one would be for oxygen and oxygen equipment.[16] Conference Report language also stipulated that the Secretary of Health and Human Services would have to find that competitive bidding resulted in cost savings compared to what would have otherwise been paid [under the fee schedule] without undermining the quality for Medicare beneficiaries.[17]

CMS conducted three CBPs: two in Florida and one in Texas. The first demonstration in Polk County, Florida (October 1999-September 2001) covered five categories of products, with between 4 and 13 suppliers selected for each category and a total of 16 winning suppliers.[18] This project saved Medicare beneficiaries 16-17% over predicted expenditures on covered items compared to reimbursement if made pursuant to the fee schedule.[19]

SERVICES, OFFICE OF THE INSPECTOR GENERAL, MEDICARE AND FEHB PAYMENT RATES FOR HOME OXYGEN EQUIPMENT (March 2005) (EOI-09-03-00160), *available at* http://oig.hhs.gov/oei/reports/oei-09-03-00160.pdf.

[11] According to CMS, "payment error rate" does not necessarily constitute fraud, but notes the measure of payments that do not meet statutory, regulatory or administrative requirements. CMS, RESEARCH STATISTICS, PAYMENT ERROR RATE MEASUREMENT (PERM), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/index.html?redirect=/PERM/.

[12] Pub. L. No. 105-33; § 4319(a), 112 Stat. 251, 392-94 (1997).

[13] 42 U.S.C. § 1395x.

[14] H.R. CONF. REP. NO. 105-217, at 726 (1997).

[15] *Id. See also* H. REP. NO. 105-149, at 751 (1997).

[16] H. REP. NO. 105-217, at 726.

[17] *Id.*

[18] SECRETARY OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO CONGRESS: EVALUATION OF MEDICARE'S COMPETITIVE BIDDING DEMONSTRATION FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES 2 (2004), *available at* http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads//CMS_rtc.pdf.

[19] *Id.*

A second round of bidding was held in Polk County, Florida in early 2001 with the same product categories, minus one, with 16 winning suppliers.[20] This project realized savings of approximately 20%. The last demonstration project, held in San Antonio, Texas, began in February, 2001, and covered hospital beds, oxygen supplies, wheelchairs and non-customized orthotics.[21] This project ended in December 2002 and saved Medicare and its beneficiaries approximately 20% over predicted expenditures.[22] According to the CMS report to Congress on these demonstration projects, products provided to beneficiaries did not change during the demonstration, and there was high beneficiary satisfaction with the suppliers.[23] Although there was anecdotal evidence of instances of issues with urological supplies and wheelchair fitting and delivery,[24] these were corrected through a new round of bidding and the increased experience of hospital staff who ordered the supplies.[25]

B. Medicare Modernization Act of 2003 (MMA)

In 2003, CMS prepared studies for Congress demonstrating the savings on DMEPOS provided to beneficiaries through CBP.[26] This led Congress to expand CBP in the Medicare Modernization Act of 2003[27] (MMA). The Act mandated that CMS replace the current fee schedule for DMEPOS for most of the country except in rural areas and metropolitan areas with less than 250,000 residents. The limitations on the CBP were that quality to beneficiaries could not be diminished and the rates paid by Medicare for DMEPOS had to be less than CMS paid under the fee schedule.

MMA required CMS to begin the CBP in ten of the largest Metropolitan Statistical Areas (MSA) in 2009, and in other areas after 2009.[28] The new CBP began with Round 1, starting in 2007. In a CBP, suppliers submit bids[29] in the amount they are willing to accept as payment to provide select DMEPOS products to Medicare beneficiaries. Not all products are subject to competitive bidding.

Using the bids submitted by suppliers, CMS determined a single payment amount for each DMEPOS item in each CBA. For the CBP, CMS adopted Medicare's longstanding rule that Medicare payments for DMEPOS items be based on the primary residence of the beneficiary, regardless of where the item is furnished.[30]

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[20] *Id.*
[21] *Id.*
[22] *Id.* at 4.
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] EVALUATION OF MEDICARE'S COMPETITIVE BIDDING DEMONSTRATION FOR DMEPOS (April 2002), *available at* http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/2rtc_Appendix.pdf.
[27] Pub. L. No. 108-173 § 4319, 117 Stat. 2066, 2223 (2003).
[28] *Id.*
[29] Bids are submitted to CMS electronically and the required documents are mailed.
[30] *Id.* at 18,000.

This payment amount replaced the fee schedule amount as payment for those items.[31] The payment for an item furnished under a CBP is 80% of the single payment amount calculated for the item.[32] The single payment amount for each item is equal to the median of the bids submitted for that item by suppliers whose composite bids for the product category that includes the item are equal to or below the pivotal bid for that product category.[33] If there is an even number of bids, the single payment amount for the item is equal to the average of the two middle bids.[34] The single payment amount for the item must be less than or equal to the amount that would otherwise be paid for the item.[35]

The MMA provided that contracts could only be awarded in an area if: 1) entities met quality standards set by the Secretary;[36] 2) entities met financial standards set by the Secretary, taking into account the needs of small providers;[37] 3) total amounts paid under contracts are expected to be less than otherwise paid; and 4) beneficiary access to multiple suppliers is maintained.[38] Suppliers agree to accept assignment of all claims for bid items, and will be paid the bid price amount, which CMS calculates from the median of all winning bids for an item.[39]

Under the MMA and the regulations adopted by CMS,[40] award of contracts to eligible bidders is a bifurcated process. First, CMS determines the universe of winning bidders by asking interested providers to bid on a group of products. CMS then determines a so-called pivotal bid (the company whose bid is highest and that can meet expected demand for products).[41] Once the pivotal bid is calculated, CMS then deconstructs the pivotal bid to identify the price that would be paid for each item based on the price for that product from all bidders below the pivotal bid.[42]

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[31] 42 U.S.C. § 1447(b)(5); Medicare Program: Competitive Acquisition for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and Other Issues, 42 Fed. Reg. 17,992-18090 (April 10, 2007) (codified at 42 C.F.R. pts. 411 and 414), *available at* https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads//cms1270f.pdf.

[32] 42 C.F.R. § 414.408(a).

[33] *Id.* at § 414.416(b).

[34] *Id.*

[35] *Id.* at § 414416(b)(2).

[36] 42 U.S.C. § 1395w-3.

[37] In developing the standards, CMS met with small business stakeholder groups, held focus groups, and posted the draft standards on line for a 60-day comment period. It made significant revisions to the standards based on the comments received. 42 Fed. Reg. 17,992 at 18,015.

[38] 42 U.S.C. § 1820(a)(20).

[39] *Hearing before the House Committee on Small Business: The Impact of Competitive Bidding on Small Businesses in the Durable Medical Equipment Community* 1 (February 11, 2009) (testimony of Lawrence D. Wilson, Director, Chronic Care Policy Group, Center for Medicare Management, Centers for Medicare and Medicaid Services), *available at http://democrats.smallbusiness.house.gov/hearings/hearing-2-11-09-sub-DME-bidding-process/Wilson.pdf.*

[40] 42 C.F.R. pts. 411 and 414.

[41] For example, if there are five bidders, and four bidders are expected to meet demand, CMS takes the four bidders from lowest to highest that fully meet market demand. This is the pivotal bid.

[42] The pivotal bid is the point where beneficiary demand is met by supplier capacity. For example, beneficiary demand is expected to be 1,000 units. Bidder 1's composite bid is $120, its supplier capacity is 400 and cumulative capacity is 800; Bidder 2's composite bid is $100, its supplier capacity is 100 and cumulative capacity is 100;

Given the facts that most DMEPOS suppliers are small businesses and beneficiaries have established relations with small businesses, CMS developed standards and rules to assist small businesses in winning contracts. However, in developing these small business considerations, CMS did not (although it could have) adopt the protections of the Small Business Act for government contractors as set forth in the Federal Acquisition Regulation.[43]

1. Small Business Considerations

CMS worked with the Small Business Administration to develop a definition of "small supplier." Under the definition, a small supplier is one that generates gross annual revenue of $3.5 million or less, including Medicare and non-Medicare receipts.[44] CMS recognized that small suppliers may not be able to service all areas in a region, so it permitted small suppliers to bid together under certain conditions.[45] To develop the acquisition quality and financial standards, CMS met with stakeholder groups, including small suppliers, and held focus groups, to give small suppliers an opportunity to express their concerns about how the standards would affect them.[46] In the final rule, CMS established a target that at least 30% of winning suppliers should be small suppliers.[47]

C. Medicare Improvements for Patients and Providers Act of 2008

After concerns were raised about CBP's Round 1 bidding and contract awards in two congressional hearings in May 2008,[48] the CBP was temporarily delayed by the Medicare

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Bidder 3's cumulative bid is $115, its supplier capacity is 300 and its composite capacity is 400; Bidder 4's composite bid is $140, its supplier capacity is 500 and its cumulative capacity is 1600; Bidder 7's composite bid is $150, its supplier capacity is 100 and its cumulative capacity is 1700; Bidder 10's composite bid is $135, its supplier capacity is 300 and its cumulative capacity is 1100. All bidders that were eligible selection and whose composite bid for the product category was less than or equal to the pivotal bid would be selected as winning bidders. The pivotal bid is $135; suppliers 1, 2, 3 and 10 are selected as winning bidders, with supplier 10's composite bid becoming the pivotal bid. 72 Fed. Reg. 18,041-2.

[43] Medicare Program: Competitive Acquisition for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and Other Issues, 42 Fed. Reg. 18,071 (April 10, 2007) (codified at 42 C.F.R. pts. 411 and 414), *available at* https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads//cms1270f.pdf.

[44] "Small supplier" means a supplier who generates revenue of $3.5 million or less in annual gross revenue (in Medicare and non-Medicare revenue). 42 C.F.R. § 414.402.

[45] *Hearing before the House Committee on Small Business: The Impact of Competitive Bidding on Small Businesses in the Durable Medical Equipment Community* 3 (February 11, 2009) (testimony of Lawrence D. Wilson, Director, Chronic Care Policy Group, Center for Medicare Management, Centers for Medicare and Medicaid Services), *available at* *http://democrats.smallbusiness.house.gov/hearings/hearing-2-11-09-sub-DME-bidding-process/Wilson.pdf*

[46] *Id.* at 2.

[47] *Id.*

[48] In Congressional hearing testimony, GAO indicated that competitive bidding for DMEPOS products can reduce Medicare program payments, but there were also concerns that suppliers might provide lower quality products and

Improvements for Patients and Providers Act of 2008[49] (MIPPAA). MIPPA terminated the existing contracts that were awarded in Round 1, and established a second round of competition, known as Round 1 re-bid.[50] The original MMA phase-in was as follows: 9 of the largest MSAs in 2007, 80 of the largest MSAs in 2009, and the remaining MSAs after 2009.[51] MIPPA delayed the Round 1 re-bid until 2011 and added 70 new competitive bidding areas to the program (for a total of 80). MIPPA also delayed the Secretary's expansion of the program beyond 80 MSAs (from after 2009) until after 2011.

In January, 2011, CMS began a CBP for DMEPOS products in nine product categories[52] in nine MSAs.[53] MIPPA required that competition for Round 2 occur in 2011 in 70 additional MSAs and authorized competition for national mail order items and services after 2010.[54] MIPPA added quality assurance measures to those instituted by MMA, requiring all DMEPOS suppliers, whether they are contractors or subcontractors, to be accredited for quality assurance by October 1, 2009.[55]

It is also important to know what MIPPA did not do. MIPPA did not fundamentally change the precepts of the MMA: competitive bidding and pivotal bids. Other than excluding certain types of wheelchairs, MIPPA provided greater protections to bidders with respect to information provided to CMS in preparation for the bids.

III. The Patient Protection and Affordable Care Act of 2010 (PPACA)[56]

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sub-standard service. See *Medicare: Competitive Bidding of Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical, Hearing Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives* (May 6, 2008) (testimony of Kathleen M. King at 3, Director, Health Care, GAO) (GAO-08-767T), *available at* http://www.gao.gov/assets/120/119966.pdf.

[49] Pub. L. No. 110-275, 122 Stat. 2494 (2009), codified at 42 U.S.C. § 1395w-3.

[50] *Id.*

[51] Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Medicare Program, 72 Fed. Reg. 17, 992 (2007) (to be codified at 42 C.F.R. pts. 411 and 414), *available at* https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads//cms1270f.pdf,

[52] A product category is made up of items that are used to treat a similar medical condition. The product categories for this round were: oxygen supplies and equipment, standard power wheelchairs, scooters and related accessories; mail order diabetic supplies; entereal nutrient equipment and supplies; continuous power airway pressure supplies; respiratory assist devices and related supplies and accessories; hospital beds and related accessories; walkers and related accessories; support surfaces and overlays.

[53] The CBAs were: Charlotte (Charlotte/Gastonia/Concord, NC and SC); Cincinnati (Cincinnati/Middletown, OH, KY and IN); Cleveland (Cleveland/Elyria/Mentor, OH); Dallas (Dallas/Ft. Worth/Arlington, TX); Kansas City (Kansas City, MO and KS); Miami (Miami/Ft. Lauderdale/Pompano Beach, FL); Pittsburgh (Pittsburgh. PA); Riverside (Riverside/San Bernardino/Ontario, CA); Orlando (Orlando/Kissimmee, FL); and San Juan (San Juan/Caguas/Guanynabo, PR).

[54] 42 U.S.C. § 1395mm.

[55] CMS, DMEPOS ACCREDITATION FACT SHEET, *available at* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads//DMEPOSAccreditiationDeadline.pdf.

[56] Pub. L. No. 111-148, 124 Stat. 119, 768 (2010).

PPACA required CMS to issue regulations[57] formalizing that only Medicare-enrolled physicians[58] or other eligible professionals[59] may prescribe DMEPOS.[60]

PPACA expanded the number of Round 2 MSAs from 70 to 91, and mandated that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016.[61] The additional 21 MSAs will be the next largest MSAs by population. PPACA also requires a face-to-face visit with a physician before DMEPOS can be prescribed.[62] This provision is effective for DMEPOS products that are ordered after January 1, 2010.

IV. Current Status of the DMEPOS Program

On April 17, 2012, CMS issued an update[63] on the DMEPOS program. According to the report, in its first year of implementation, the DMEPOS program saved Medicare about $202.1 million, a drop in expenditures of 42% in the nine markets in which the program currently operates.[64] CMS also reported that it found no disruption in access to supplies by beneficiaries, no "negative health care consequences,"[65] and minimal complaints from beneficiaries.[66] In the fourth quarter of 2011, CMS received only six beneficiary complaints.[67]

In addition, CMS provided data in its report demonstrating that in similar CBP and non-CBP populations, the average rate of physician visits, hospitalizations, emergency room visits, skilled nursing facility admissions and death were the same.[68]

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[57] Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements, 75 Fed. Reg. 24,437 (2010) (codified at 42 C.F.R. Pts. 424 and 431), *available at* http://www.gpo.gov/fdsys/pkg/FR-2010-05-05/pdf/2010-10505.pdf.

[58] An enrolled physician is one who has registered with the Medicare in accordance with the rules established by the Secretary. *See* Pub. L. No. 111-148, 124 Stat. 768 and 42 U.S.C. § 1395cc(j).

[59] An eligible professional is defined in PPACA as one who has enrolled with Medicare's Quality Care Reporting System for providers. The Social Security Act defines eligible professional as a physician, practitioner (including certified nurse anesthetist, certified midwife, clinical social worker or clinical psychologist), physical or occupational therapist or qualified speech-language pathologist. *See* 42 U.S.C. § 1395w-4(k)(3)(B).

[60] Pub. L. No. 111-148 § 6405(a); *see also* 42 C.F.R. § 424.506 et seq. (May 5, 2010).

[61] Pub. L. No. 111-148 § 6410 (b), 124 Stat. 773.

[62] Pub. L. No. 111-148 § 6407(a), 124 Stat. 770.

[63] CENTERS FOR MEDICARE AND MEDICAID SERVICES, COMPETITIVE BIDDING UPDATE—ONE YEAR IMPLEMENTATION UPDATE, April 17, 2012 [hereinafter CMS Update], *available at* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads//DMEPOSAccreditiationDeadline.pdf.

[64] CMS Update at 1.

[65] *Id.*

[66] CMS received 127,466 beneficiary inquiries regarding the competitive bidding program during 2011. This represented less than 1% of the calls received at the 1-800-Medicare call center. Most inquiries were routine requests, such as information about the program or locating a supplier. CMS Update at 6.

[67] CMS Update at 6.

[68] *Id.* at 16.

According to the report, each Round 1 area had multiple winners for each product category.[69] About 51% of the winning suppliers are small suppliers.[70] This total exceeded CMS's goal of 30% small suppliers.[71]

The CBP will expand to an additional 91 MSAs in 2013. CMS' Chief Actuary estimates that the program will save the Medicare Part B Trust Fund $25.7 billion between 2012 and 2022.[72] Beneficiaries are expected to save an estimated $17.1 billion during the same period.[73]

V. Small Business Concerns

Most DMEPOS suppliers are small businesses, defined as those with gross annual revenue of $3.5 million or less. In fact, for Round 1, approximately 51% of winning suppliers are small suppliers, which exceeded CMS' goal of 30%.

Because of concerns that Round 1's bidding was unfair, Congress terminated the program and caused it to be re-bid after CMS made improvements. Because the program is slated to expand in 2013, we must ensure not only that the program uses taxpayer and beneficiary dollars wisely, but also that it is fair to them and suppliers.

Some small suppliers have expressed concerns about the implementation of the current program.[74] They have said that it forces providers to reduce support services in order to meet lower reimbursement rates.[75] They have also said that some winning bidders have reported receiving no business. Small suppliers have complained that a significant reduction in suppliers based on winning bids has resulted in less competition and reduced access. Others have said that non-local suppliers winning contracts has resulted in reduced access for seniors and rural areas. There is no one-stop shopping for customers if a supplier can furnish only one item (e.g., oxygen) and customers must go elsewhere for others. There have been reports of medical equipment delivery delays, slower response to physician equipment orders, and decreases in business for non-winning bidders.[76] Concerns have also been raised about the asset verification process and the fact that bids are non-binding.[77]

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[69] *Id.* at 2.
[70] "Small supplier" was defined as one with gross annual revenue of $3.5 million or less. *Id.*
[71] CMS Update at 2.
[72] *Id.* at 1.
[73] *Id.*
[74] *Hearing on the Medicare Durable Medical Equipment Competitive Bidding Program Before the House Committee on Ways and Means,* 112th Cong. 2 (2012) (statement of Joel D. Marx, Chairman, Medical Service Company), *available at* http://waysandmeans.house.gov/UploadedFiles/Marx_Testimony_Final_5-9-12.pdf.
[75] *Id.*
[76] *Hearing on the Medicare Durable Medical Equipment Competitive Bidding Program Before the House Committee on Ways and Means,* 112th Cong. 2 (2012) (statement of H. Wayne Sale, Chair, Board of Directors, National Association of Medical Equipment Suppliers), *available at* http://waysandmeans.house.gov/UploadedFiles/Sale_Testimony_Final_5-9-12.pdf.
[77] Brian Merlob, Charles R. Plott & Yuanjun Zhang, *The CMS Auction: Experimental Studies of a Median-Bid Procurement Auction with Nonbinding Bids*, 127 The Q. J. of Econom. 793, 797 (May 2012), *available at* http://www.thecre.com/blog/wp-content/uploads/2012/06/The_CMS_Auction.QuarterlyJournalofEconomics.May2012.pdf.

Small business owners have said the reason that the program's beneficiary complaint totals are so low is that beneficiaries are often elderly, ill and tired, so they become frustrated with staying on hold with the Medicare hotline and simply hang up before registering their complaints.[78] Small suppliers do not understand how CMS can keep prices low when forcing thousands of small businesses to be eliminated from the program, leaving fewer suppliers and increasing numbers of consumers.[79] Some believe the program should be suspended or repealed.[80]

VI. Conclusion

The Medicare program faces a very challenging future. With rising health care costs and an aging population, its sustainability is at serious risk. In their most recent report, the Medicare Trustees estimated that Medicare expenditures represented 3.7% of GDP in 2011, and under current law, costs would increase to about 5.7% of GDP by 2035 and to 6.7% by 2080.[81] However, even those expenditures are understated because of the inability to sustain reductions in certain costs, such as the reductions to physician payments that are scheduled in future years under current law.[82] According to an analysis by Charles Blahous, one of the Medicare trustees, the Medicare Hospital Insurance Fund will exhaust its assets by 2029, and PPACA will add over $340 billion to the federal deficit over the next ten years.[83]

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[78] *Id.* at 3.
[79] *Id.* at 4.
[80] *Id.at 5,*
[81] THE BOARDS OF TRUSTEES, FEDERAL HOSPITAL INSURANCE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, 2012 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 21, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf.
[82] *Id.*
[83] *See* CHUCK BLAHOUS, MERCATUS CENTER, GEORGE MASON UNIVERSITY, THE FISCAL CONSEQUENCES OF THE AFFORDABLE CARE ACT, April 10, 2012, *available at* http://mercatus.org/publication/fiscal-consequences-affordable-care-act; and Chuck Blahous and James Capretta, *Exposing the Medicare Double Count*, WALL ST. J. May 1, 2012, *available at* http://online.wsj.com/article/SB10001424052702304299304577346332422834276.html?mod=googlenews_wsj.