The State of Expert Judgment Regarding Medicare's Competitive Bidding Program for Durable Medical Equipment

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Executive Summary

The Centers for Medicare and Medicaid Services (CMS), as required by the Affordable Care Act, has recently adjusted the fee schedule for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), lowering reimbursement levels for hundreds of products, using information the agency gathered through the Medicare DMEPOS Competitive Bidding Program. While this may save money in the short run for the Medicare program and Medicare beneficiaries who pay a percentage of the price of the durable medical equipment, economists, DME suppliers and others familiar with the DME market have serious doubts about the validity of the pricing data coming from the program.

The Moran Company was engaged by the Council for Quality Respiratory Care (CQRC) to review the policy environment surrounding Medicare reimbursement for durable medical equipment (DME) under the competitive bidding program. In this report, we review the history and intent behind the program, what experts have said about the design and implementation of the program, and how problems persist as competitive bid pricing information is used to develop reimbursement amounts for DMEPOS products nationwide.

- The DMEPOS Competitive Bidding Program was developed to lower what were regarded to be inappropriately high fee schedule amounts for DMEPOS. At the same time, CMS sought to protect beneficiary access to the products they needed through various patient protection and supplier quality provisions.
- Several design decisions related to the calculation of the new bid prices have been called into question by economists and other experts.
    - The use of non-binding bids allows bidders to submit unrealistically low bids, knowing that if they are selected, and the ultimate bid price is too low to cover their expenses, they can simply refuse to enter into a bidding contract.
    - CMS also instituted a system in which payment amounts are calculated based on the median bid. This means that roughly half of the selected bidders will be paid higher than the price they bid, while half will be paid less.
    - The use of composite bids—bids that are weighted compilations of several products into one bid price—also provides incentives for bidders to try to game the system by bidding low for some products and high for others, leading to skewed pricing information for individual products.
    - These issues, taken together, mean that the Competitive Bidding Program does not determine true market clearing prices, and thus the bid price information derived from the program is limited in value.

  - CMS's selective release of information pertaining to the program does not allow analysts to study the program, its effects on the market and the overall sustainability of the prices.
- Although CMS has made some efforts to improve the program, evidence has arisen to suggest that problems still exist.
  - A recent Office of the Inspector General report found that high percentages of suppliers do not meet state licensure requirements, suggesting that CMS's quality requirements for bidders may not be sufficient.
  - CMS has noted the existence of "inversions" arising from "unbalanced bidding." In "inversion" situations, the competitive bidding rates for certain items with additional product features can be lower than the single payment amounts for similar products without those features.
- As required by law, CMS has begun using competitive bidding pricing information to reduce the reimbursement rate of DMEPOS products nationwide.
- However, the application of competitive bidding prices across the board does not recognize the trade-off bidders faced when developing their bids. Only selected bidders were able to supply DMEPOS in the bid areas. Because of this selective contracting, bidders were able to bid lower prices, knowing they would have higher sales volumes since fewer suppliers would have access to the market.
- Given the problems with the Competitive Bidding Program outlined in this report, doubt has been cast on the validity of the pricing information the program has produced. Applying this information nationwide, to non-competitively bid areas, could lead to unsustainable reimbursement levels.

Statutory Intent and Design Constraints

Prior to the establishment of the Medicare DMEPOS Competitive Bidding Program, the Medicare DMEPOS market faced two main policy concerns. First, there had long been concerns among lawmakers and other policymakers that Medicare's fee schedule for DME was outdated and overly generous. Reports from The Department of Health and Human Services (HHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO) suggested that Medicare paid higher than market rates for some DMEPOS items. These possible pricing disparities increased costs to both the Medicare program and the beneficiaries responsible for paying 20 percent of the DME purchase price. In addition to concerns about cost, various investigations uncovered fraud and abuse among some DMEPOS suppliers. GAO estimated that Medicare made about $700 million in improper payments for DMEPOS from April 1, 2005 through March 31, 2006.[1]

In hopes of finding solutions to these two problems, Congress included provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which required CMS to create a competitive bidding program for DMEPOS and to develop a set of quality standards for DME suppliers. The purpose of this program was to allow the market to

[1] GAO, Medicare: Improvements Needed to Address Improper Payment for Medical Equipment and Supplies, GAO-07-59, January 2007, p. 1.

help determine prices, and by having suppliers compete for a smaller number of supplier slots, policymakers believed, there would be an incentive to drive bid prices lower.

Competitive Bidding Demonstration

Competitive bidding of DMEPOS within Medicare first arose out of The Balanced Budget Act of 1997 (BBA), which authorized implementation of up to five demonstration projects. In response, CMS developed the DMEPOS Competitive Bidding Demonstrations from 1999 to 2002 in Polk Country, Florida and in the San Antonio, Texas Metropolitan Statistical Area (MSA).

Both demonstration project locations employed a four part bid evaluation process. After bidders met basic eligibility standards, a composite bid for each bidder was calculated, and a cutoff composite price was determined. Bidders below the cutoff price were included for further evaluation, where referral agents, such as hospital discharge planners, social workers, and home health workers, were required to submit references. Finally, on-site inspections were made to ensure that the selected bidders met all requirements.

The bid selection process of the demonstrations differed from what CMS implemented in Round 1 of the permanent program in a few key ways. Selected bidders in the demonstration program were reimbursed at the level they had bid. This differs from the reimbursement of bidders in Round 1 of the current program, who all received the same single payment amount.

Another major difference between the competitive bidding demonstration project and the program as implemented in Round 1 was that any supplier willing to accept the competitively bid payment amount was permitted to supply DMEPOS in the demonstration areas. By not restricted the number of suppliers, beneficiaries could continue to purchase their supplies from the same provider as they had previously, maintaining continuity of care.

The final evaluation of the demonstration project, prepared by RTI International, reported that demonstration prices in both locations were lower than the existing fee schedule for most items. RTI concluded that there was little or no effect on utilization, and that the program reduced Medicare expenditures by about $7.5 million and beneficiary payments by about $1.9 million.[2]

Competitive Bidding Round 1

After the competitive bidding demonstration project showed savings to Medicare without major beneficiary access problems, Congress included language in the MMA in 2003 requiring CMS to expand the program. In the first round of the program, CMS selected ten metropolitan statistical areas (MSAs) and ten categories of DMEPOS to be included.

[2] Karon, et. al., Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS Final Evaluation Report, RTI Project Number 07346.002.011, November 2003, p. 4.

Selecting the Product Categories

In selecting the products subject to competitive bidding, CMS focused "first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential."[3] CMS decided that the following product categories would be included in Round 1 of the DMEPOS Competitive Bidding Program:

- Oxygen supplies and equipment;
- 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 (CPAP) devices, respiratory assist devices (RADs), and related supplies and accessories;
- Hospital beds and related accessories;
- Negative pressure wound therapy (NPWT) pumps and related supplies and accessories;
- Walkers and related accessories; and
- Support surfaces (group 2 and 3 mattresses and overlays — Miami and San Juan only).[4]

Each product category included multiple individual items, defined by HCPCS codes. CMS was not explicit about the reasons for the inclusion of certain supplies within those categories, and exclusion of others.

Suppliers were required to bid on all of the items in a product category and had to agree to furnish those items to all Medicare beneficiaries within a competitive bidding area (CBA). In the contracts with the winning suppliers, however, product substitutions were permitted.

Determining the Winning Bids

Each supplier was required to submit a bid price and expected volume the provider could supply for each item in a category. These individual product bids were weighted and grouped into composite bids to allow comparability across bidders. CMS used Medicare claims data for the previous two years and the number of new Medicare enrollees in each CBA to determine beneficiary demand for the products. Then, CMS evaluated and ordered the composite bids from lowest to highest, and selected those that fell at or below a pivotal point, which CMS determined as the lowest composite bid the agency could accept in order to meet beneficiary demand. CMS used the pivotal point to determine the single payment amounts for each CBA.

In the example depicted in the table below, three suppliers would be chosen because the third supplier—the pivotal bid—would be the lowest bid that would cumulatively meet the expected demand of 500 units.

[3] MMA- Pub.L. 108-173, 117 Stat. 2225.
[4] When CMS implemented Round 2, two product categories—mail order diabetic supplies and support surfaces—were not included.

Table 1. Pivotal Bid Example

Pivotal Bid Example based on a hypothetical CBA with a beneficiary utilization of 500			
	Composite Bid Amount	Supplier Capacity	Cumulative Capacity
Supplier A	50	175	175
Supplier B	52	150	325
Supplier C	55	180	505
Supplier D	60	250	755
Supplier E	70	200	955

The Single Payment Amount

Reimbursement to selected contractors was to be based on the median of the chosen bids (i.e., the pivotal bid and lower). In Table 1, supplier C is the pivotal bid, meeting expected demand of 500 units. If the bids were for a specific item (rather than a composite bid), CMS would select the median bid of the selected suppliers to determine the single payment amount for that item. In the example above, that would be $52.00. The three selected suppliers (A, B, and C) would all be offered contracts, and each would be reimbursed at $52. In general, taking the median of the chosen bids means that half of the selected suppliers will be reimbursed at a level higher than they bid, and half would receive a lower reimbursement amount than their bid. This system differs from the demonstration project, which reimbursed each supplier at its bid amount.

Using the median bid to determine the single payment amount encourages bidders to game the system. A bidder could submit an unsustainably low bid, in order to ensure that it is selected, knowing that it will be reimbursed at the higher single payment amount. Bidders submitting such low bids will drag the single payment amount down, but the low bidders can then decide whether the single payment amount is sufficient to cover their expenses. If not, they can back out of the program, leaving those suppliers that do decide to participate with the artificially low single payment amount. CMS will not change the single payment amount, even if bidders refuse to participate and bidders who initially did not win bids because they were too high are invited to participate.

Beneficiary Protections

CMS included several items to protect beneficiaries in its implementation of the DMEPOS Competitive Bidding Program. As discussed above, it based its calculation of the pivotal bid on supplier capacity, as well as cost. Suppliers are required to make a reasonable effort to furnish the brand name item or mode of delivery when prescribed by the physician. In addition, CMS established a Program Advisory and Oversight Committee (PAOC). Finally, although technically separate from the DMEPOS Competitive Bidding Program, CMS implemented an accreditation program for all DMEPOS suppliers, as required by the MMA.

Expert Commentary on Early Phases of Design

Concerns about the structure and implementation of the DMEPOS Competitive Bidding Program's first round arose quickly. Economists and others involved in the DME market questioned whether the bid methodology was sustainable and would allow CMS to meet the program's goals.

A report by two economics professors at Robert Morris University states, "the economic literature contains a number of descriptions of "the winner's curse." Often the successful bidder will have the low bid because it has made mistakes in estimating its future costs at the time of bidding. In this case the firm that has won the bid has offered to sell the product at an inordinately low price, perhaps lower than it can afford. Thus, the firm must cut costs even below those that it estimated. The most likely target for cost reductions is customer service. This is made even easier by the lack of competition. Consumers have few alternatives so poor service becomes commonplace."[5]

The economists also address the limitations on the number of selected bidders and conclude "Artificial limits on supply will produce artificial shortages and access problems in the intermediate run (five to 20 years), will ultimately increase price and reduce social welfare and will, more likely than not, result in monopoly profits for the successful bidders that CMS will have little incentive or ability to regulate…CMS should take steps to enhance competition in the market for DME rather than adopting artificial limitations."[6]

CMS received more than 2,000 comments in response to the May 1, 2006 proposed rule regarding the implementation of the DMEPOS Competitive Bidding Program.[7] The comments covered a wide range of topics, from suggestions for ways to lower DME prices without going through the bidding process, to concerns about program oversight, to questions about how CMS selected the products covered under the program.

Commenters also noted problems with the single payment amount methodology. "Several commenters expressed concerns that the proposed method to determine the single payment amount would result in suppliers submitting low bids and only offering the lowest cost devices. They believed that quality and access would be impacted by the use of the median bid. They further indicated that requiring savings on each item rather than in the aggregate encourages suppliers to bid on the oldest, lowest priced product within each HCPCS code."

CMS also noted that "Several commenters argued that the use of the median bid to set the single payment amount is flawed because the median bid could be vulnerable to a variety of gaming strategies. They noted that, when using the median, 50 percent of winning bidders would have to accept less than their bids to participate…Numerous commenters suggested that CMS use the Adjustment Factor Method (AFM) that was used during the demonstration. Because suppliers

[5] Brian O'Roark and Stephen Foreman, "The Impact of Competitive Bidding on the Market for DME," February 11, 2008, http://www.vgmncbservices.com/common/docs/legislative/O'Roark-Foreman_Impact_Study.pdf.
[6] Ibid.
[7] *Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues; Final Rule.*

were paid at least as much as they bid in aggregate, commenters believed that the AFM would provide sufficient protections to encourage small suppliers to bid."

Return to Congress

In response to the concerns raised by Medicare suppliers, academics, policymakers and others about illegitimate bids and other problems with Round 1, Congress included provisions in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[8] that delayed the start of the program. MIPPA terminated the Round 1 contracts that were in effect and reinstated fee schedule payment rates, required rebidding of the first round at a later date, and imposed a nationwide 9.5 percent payment reduction for all Round 1 items in 2009. The law also expanded the program's geographical reach in Round 2.

The ACA (P.L. 111-148 and P.L. 111-152) subsequently expanded the number of Round 2 MSAs from 70 to 91 and mandated that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments to the fee schedule using competitively bid rates by 2016."[9]

The Economists Weigh In

In June of 2011, 244 "economists, computer scientists and engineers with expertise in the theory and practice of auctions" wrote a letter to the White House highlighting the inefficiencies of the CMS competitive bidding. This letter was supplemented over the past several years with a number of economic studies, articles and commentaries on how the DMEPOS Competitive Bidding Program was established in such a way as to work counter to CMS' goals of lowering prices while still maintaining patient access to needed products and services. These experts cited the facts that the bids are non-binding, based on the median bid price, and are combined to create composite bids as especially problematic. These methodology decisions mean that the auctions do not arrive at actual market clearing prices. Finally, the lack of transparency in the bidding process is another problem that stymies the program's ability to establish appropriate and sustainable prices for DMEPOS products.

[8] P.L. 110-275

[9] Wilson, *Medicare's Durable Medical Equipment Competitive Bidding Program: How Are Small Suppliers Faring?*, sec. Committee on Small Business, Subcommittee on Healthcare and Technology.

Non-Binding Bids and Median Bid Pricing

Experts have raised the non-binding nature of bids as perhaps the most problematic design decision CMS made in creating the bidding program. Both bidders who were offered contracts lower than and higher than their bidding price did not have to accept the contract. This provided the incentive for bidders to submit artificially low bids at prices the supplier never intended to honor. Additional problems arise because the selected bid price is the median price of the accepted bids, rather than the actual bid amount. Under the median price system, bidders can bid extremely low to become one of the accepted bidders, but then receive a higher bid price.

One economic paper characterized the process as irrational. "The rational strategy for suppliers under the CMS rules was to underbid contracts to ensure they receive a contract offer while hoping they receive the offer at a price sufficiently over their bid to make it worth accepting. Since all bidders have an incentive to bid low, the entire bidding process is distorted. CMS' auction rules are analogous to staging a poker game in which players are allowed to withdraw their wager from the pot after the cards are dealt, a situation which would not be conducive to producing a rational, sustainable game."[10]

In addition to distorting the pricing, non-binding bids can lead to market inefficiencies and undersupply. "Allocation inefficiency arises because symmetric equilibrium bid functions do not exist under realistic assumptions. Quantity inefficiency occurs because the median price is set below some winning bidders' costs and thus the median-price auction is not ex post Individually Rational, leading some demand to go unfulfilled."[11]

Finally, CMS uses all bids—even those of providers who do not accept contracts—to establish the median bid price. This can cause significant problems with the payment calculations because the "low-ball" bids, some of which may have been made with no intention of being fulfilled, distort the actual payment amount.

CMS has responded to concerns about bidders making inappropriately low bids. Testifying before Congress, Laurence Wilson, Director of the Chronic Care Policy Group which administers the program stated, "The bid scrutiny starts with our low-ball bid process… Essentially we screen out the lowest bids in a product category. We use a statistical measure to screen out the bottom ones. And then we ask the supplier to support that bid by providing information that shows us that they can obtain the product for less than what they bid and allow for the cost of the services to deliver to a beneficiary…within the bona fide bid process, we have thrown out bids where they could not document a price."[12] Despite this process, CMS estimates that seven percent of suppliers rejected contracts in Round 2.

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[10] Tozzi and Levinson, "Auctioning Healthcare: The Need for a Clinical Trial of CMS' Competitive Bidding Program for Durable Medical Equipment."

[11] Cramton, Peter, Sean Ellermeyer, and Brett Katzman. "Designed to fail: The Medicare auction for durable medical equipment." Economic Inquiry 53.1 (2015): 469-485.

[12] Laurence Wilson, *Hearing on the Medicare Durable Medical Equipment Competitive Bidding Program* (Subcommitte on Health of the Committee on Ways and Means, 2012), http://waysandmeans.house.gov/hearing-on-the-medicare-durable-medical-equipment-competitive-bidding-program/.

Composite Bids

The DMEPOS Competitive Bidding Program methodology doesn't determine suppliers or bid amounts based on bids for individual products. Instead, CMS calculates a weighted bid for each product category. First, CMS multiplies the volume or units of a product by the supplier's bid price for the item. Then the composite bid is calculated by adding all the weighted bids for the individual products in the category.

The composite bid system creates incentives for bidders to try to game the system. Economists Cramton and Katzman write "Bidders submit low bids on products for which the government has overestimated demand and high bids on products where the government has underestimated demand. As a result, prices for individual products do not align with costs, likely resulting in selective fulfillment of customer orders."[13]

Katzman and McGeary agree that the composite bid may lead to patient access issues for some products. "The fact that when a firm bids high on one good it must correspondingly bid low on another good in order to reach its targeted composite bid introduces additional, less quantifiable ramifications as well. Specifically, if the price of a good is bid too low, firms may tacitly avoid supplying it, thereby increasing consumer search costs and decreasing quality of service.[14]

Clearing Price

CMS's selected design options described above—lack of binding bids, median bids and the use of composite bids—establish a system in which the auction does not actually determine the true market clearing price in which the amount supplied equals demand.

Tom Bradley of the Congressional Budget Office, stated in a Medicare auction conference panel, "The auction mechanism that CMS used in the first round was poorly suited to the task of revealing that sustainable market price. That auction mechanism creates very strong incentives for bidders to submit bids that are below the amount at which they're willing and able to commit to deliver, and CMS's price setting mechanism, . . . doesn't reveal the same old market clearing prices…I think, the probability of failure in a subsequent round of bidding is very high because mechanisms they use aren't actually designed to reveal those prices."[15]

Tozzi and Levinson agree, "One of the results of CMS' use of what are essentially arbitrary prices is that market-clearing price information is not communicated. Because the first round bid results are not communicating information to the market, which includes future Competitive Bidding Areas (CBAs), the agency is setting itself and Medicare beneficiaries up for future auction failure."[16]

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[13] Cramton, Peter, and Brett E. Katzman. "Reducing healthcare costs requires good market design." The Economists' Voice 7.4 (2010).
[14] Katzman, Brett, and Kerry Anne McGeary. "Will competitive bidding decrease medicare prices?." Southern Economic Journal (2008): 839-856.
[15] "Medicare Auction Conference: Final Panel: What Have We Learned?" (University of Maryland, April 1, 2011), http://www.cramton.umd.edu/papers/health-care/.
[16] Tozzi and Levinson, "Auctioning Healthcare: The Need for a Clinical Trial of CMS' Competitive Bidding Program for Durable Medical Equipment."

Lack of Transparency

Questions have also been raised about the program's lack of transparency. Although CMS releases the names of the selected bidders and the single payment amounts, the agency does not provide information on the bids that were included in the pivotal amount calculation or the bidders who were not selected. This lack of information makes replicating the calculations impossible, and does not allow researchers to determine the effect of low-ball bids on the payment amount.

These issues—non-binding bids, median price bids, composite bids, inability to find a clearing price and a lack of transparency—taken together, lead to an arbitrary pricing scheme. According to economist Peter Cramton, "CMS set arbitrary prices for Medicare Durable Medical Equipment (DME) supplies based on CMS' flawed bidding process. It was not the bidders who set the prices, but CMS through its arbitrary manipulation of the quantities associated with each bidder. CMS was able to pick any price between the lowest bid made by any bidder and the highest bid made by any bidder through its selection of quantities. The CMS-set quantities are never revealed and never used for anything but setting the price. This is why the CMS process is not an auction at all, but an arbitrary pricing process."[17]

Economists from The Center for Regulatory Effectiveness came to a similar conclusion. "Medicare's competitive bidding regulations for Durable Medical Equipment (DME) create an acquisition program that has the form, but not the function, of an auction. Federal and academic experts have explained that CMS' design for the bidding program violates accepted tenets of auction theory, selects an essentially random set of vendors, and results in a supply situation that is not viable."[18]

Implementation Problems Continue

As CMS has continued to implement the DMEPOS Competitive Bidding Program through additional rounds and rebids, problems continue to arise, calling into question the ability of the agency to manage the program, and the accuracy of the pricing information being developed through competitive bidding.

The OIG Report on State Licensure

The Office of the Inspector General (OIG) received Congressional requests to investigate complaints that some bidders awarded contracts in Round 2 did not meet state quality and licensure requirements. The OIG reported that "of the 146 suppliers covered in our audit, we determined that:

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[17] Peter Cramton, "Anatomy of a Failed 'Auction' for Medicare Supplies," *Market Design Blog*, January 30, 2013, http://www.cramton.umd.edu/blog/2013/01/30/anatomy-of-a-failed-auction-for-medicare-supplies/.

[18] Tozzi, Jim J. and Levinson, Bruce, Auctioning Healthcare: The Need for a Clinical Trial of CMS' Competitive Bidding Program for Durable Medical Equipment (May 1, 2012). Available at SSRN: http://ssrn.com/abstract=2712483 or http://dx.doi.org/10.2139/ssrn.271248.3

- 69 had met State licensure requirements
- 63 had not met State licensure requirements for some of the competitions for which they received a contract
- 14 need to be further researched by CMS and its contractors to determine whether the suppliers met State licensure requirements."[19]

In the report, the OIG notes that states establish their own licensure requirements, and can change them frequently, quickly and without notifying CMS, making it difficult for CMS and CMS's contractor administering the DMEPOS Competitive Bidding Program to ensure suppliers are meeting the appropriate requirements. However, the OIG also notes that suppliers are required to maintain any applicable licenses.

The OIG report calls into question the ability of CMS's contractor to implement the quality control requirements of the DMEPOS Competitive Bidding Program. The report also indirectly suggests that the expansion of the program and the fact that some bidders, with little experience in particular geographical areas or with particular product categories, may be reasons behind the licensure problems. The report states that "a supplier that may have historically served only one State may now be part of a CBA that also includes neighboring States. Any contract supplier serving a multi-State CBA must meet licensing requirements in each of those States. A supplier may meet all the licensure requirements in one competition within one State but not meet licensure requirements in another competition in the same State. Also, a supplier may meet all licensure requirements for a product category in one State but not meet licensure requirements for the same product category in another State."[20]

Inversion & Other Evidence of Over-Complexity

The Secretary has the authority under 1862(s) to adjust or replace DMEPOS Fee Schedule values with values derived from the DMEPOS Competitive Bidding Program.[21] As the Secretary works to expand application of competitive bidding rates to areas not subject to competitive bidding,[22] a problem has emerged—which CMS has labeled as payment rate "inversions" resulting from "unbalanced bidding."[23]

The outcome of this inversion is that competitive bidding rates for certain items with additional product features can be lower than the single payment amounts for similar products without those features. As a result, vendors can receive payments above the fee schedule if they can divert volume from the highly-discounted "with feature" version to the more highly reimbursed plain vanilla product.

CMS has not acknowledged that "unbalanced bidding" could be an artifact of its ratesetting methodology, under which the "composite bid" is determined by weighting together individual

[19] "Incomplete and Inaccurate Licensure Data Allowed Some Suppliers in Round 2 of the Durable Medical Equipment Bidding Program that Did Not Have Required Licenses" (Department of Health and Human Services Office of the Inspector General, May, 2016), https://oig.hhs.gov/oas/reports/region5/51300047.pdf.
[20] Ibid., p. 2.
[21] §1842(s)(3)(B)
[22] CMS-1651-P, p. 160ff
[23] Ibid., p. 163 ff.

prices bid for both high and low volume products. Rather, in its discussion of the issue, CMS suggests that the "inversions" may be true price signals, reflecting, for example, volume-based rebates from manufacturers to suppliers.

CMS represents that its proposed solution—"lead item" bundling of related items into one single payment amount based on the weighted average of bid prices—will reflect whatever underlying market information is coming through these prices, and hence will be superior to the approach they applied to enteral infusion pumps and non-complex power wheel chairs last year.

The practical effect, however, is to move away from competitively bid prices towards a substitute administered pricing regime in an effort to solve a problem that appears to be a consequence of the way in which CMS elected to design this procurement. Their solution seeks the technical advantages inherent in an alternative approach to competitive bidding, in which suppliers could have been required to offer category-wide percentage discounts off the existing fee schedule values, thus preserving payment relativities across items. CMS could have then selected the market-clearing percentage discount, and applied that to the fee schedule values for the suppliers who bid discounts at or above the market-clearing level.

Conclusion

The DMEPOS Competitive Bidding Program has been criticized since its implementation for design decisions that incentivize bidders to submit bids that are artificially low. In addition, CMS used selective contracting, providing bidders with additional incentives to bid low, knowing that they could make up lost revenue through higher volume. Now, as CMS applies these competitively bid prices to the DMEPOS fee schedule and subjects suppliers nationwide to these prices without the advantages of selective contracting, concern has been raised about the sustainability of the prices, the ability of suppliers to remain in the market, and beneficiary access to needed DMEPOS products and services. Based on our review of the system to date, we do not believe that the adjusted fee schedule is any more "accurate" than the prior prices in the DMEPOS fee schedule, and is likely to be unsustainable for suppliers.