The Rationale for Reforming Medicare Home Respiratory Therapy Payment Methodology

MARCH 14 • 2018
EXECUTIVE SUMMARY

The question of access to DMEPOS equipment, supplies, and services generally, and home respiratory therapy more specifically, is one that has raised strong opinions on both sides of the issue. Because of the complexity of the population, there are no easy answers, but it is clear that the payment cuts of the last several years have led to substantial pressure on the home respiratory therapy providers, who for the most part have insulated patients from the reality of the cuts. That insulation, however, has come to an end. In short, arbitrary payment cuts are driving providers from the market. Provider departures in many markets threaten beneficiary access to timely oxygen and sleep therapies. If home respiratory therapy usage declines, patients will experience adverse health outcomes which will increase Medicare spending in other settings including emergency departments, hospitals, and other post-acute care settings. The cost of these more expensive settings will eliminate any of the savings CMS has achieved in the short-term under the competitive bidding program (CBP).

While the rates set by CMS prior to competitive bidding may have been higher than the cost of providing the services, the manner in which the CBP has been implemented has resulted in rates that are too low. Despite claims by CMS that access, volume of services, and health care outcomes remain unchanged under the program, analyses of CMS data and surveys of patients and health care professionals, as well as evaluations of the competitive bidding rate setting methodology show that the program has taken too much money out of the system, harming patients.

This paper summarizes the evidence to date supporting the conclusion that payment policies, while well-meaning initially, have been implemented in a manner that is not only impacting beneficiary access to medically necessary services, but will also decrease their quality of life and lead to worsening health care outcomes. In turn, the Medicare program is likely to spend more money on hospitalizations and readmissions than it is saving on home respiratory therapy services.

This trend is disturbing in the area of home respiratory therapy in particular. COPD, the primary diagnosis associated with the need for home respiratory therapy, is the third leading cause of death in the United States. Almost 15.7 million Americans (6.4 percent) reported that they have been diagnosed with COPD. More than 50 percent of adults with low pulmonary

---

1Sean Cavanaugh, “The Proof is in the Numbers: DMEPOS and Health Outcomes Data” (June 7, 2016).
function were not aware that they had COPD, so the actual number may be higher. It affects 11 percent of all Medicare beneficiaries each year.

COPD poses a major economic burden to the United States. The total cost of managing COPD in 2005 U.S. dollars was estimated at $38.8 billion, of which $21.8 billion represented direct costs. COPD accounts for one fifth of all hospitalizations in individuals aged 75 years and older, and comorbidities are common in patients with COPD and associated with significant additional health care cost. Medicare health care expenditures are 2.5 times higher for elderly patients with COPD compared with age-matched persons without the condition. COPD patients aged 65 years and older enrolled in a Medicare managed care plan have $20,500 in additional annual expenditure compared with age- and sex-matched comparison groups.

The Moran Company analyzed 2016 CMS claims data and confirmed that COPD beneficiaries incur more health care costs than other beneficiaries. Most interestingly, newly-diagnosed COPD patients who start oxygen therapy within two months of first diagnosis have total health care costs downstream of that diagnosis that are about 20 percent lower than those who start oxygen later. This finding raises the policy concern that patients who delay oxygen therapy due to access problems in the early stage of treatment may generate health system costs that are materially larger than whatever savings CMS may be achieving via payment cuts.

According to data from the Medicare, 5 Percent Standard Analytic File and the Part B National Summary File, the percentage of the Medicare population receiving home oxygen services declined by 42 percent between 2008 and 2014. Over that same period, the total Medicare population grew by 19 percent. The numbers are even worse when analyzing the increase in COPD diagnoses. Over this period, the Medicare aged population experienced a 59 percent increase in COPD diagnoses, the main indicator for prescribing home respiratory care. Yet, what’s more troubling is that the percentage of Medicare patients with COPD receiving home oxygen therapy declined over this same period.

The logical extension of this fact is that these patients are having to manage their disease through emergency department visits, hospitalizations, and seeking long-term care in nursing homes. Section II describes how the competitive bidding program is creating real problems for patients, health care professionals, and providers/suppliers.

---


7The Moran Company available upon request.

8Tim Pigg, “Cuts to Home Respiratory Care Providers Endanger Medicare Seniors' Health” Morning Consult (March 2, 2017).
Over the years, the Medicare program refuted concerns raised by patient advocates, providers, health care professionals, and payment policy experts by focusing on a narrow definition of access to support its contention that there is no problem with the Medicare program’s rates. However, as this paper sets forth, that conclusion is based on faulty premises that need to be questioned.

As initially articulated by the Centers for Medicare & Medicaid Services (CMS), the goals of the competitive bidding program were to:

- Assure Medicare beneficiaries access to quality DME products and services;
- Reduce the amount Medicare pays for DME under a payment structure that is reflective of a competitive market;
- Limit the financial burden on beneficiaries by reducing out-of-pocket expenses, and;
- Contract with providers that conduct business in a manner that is beneficial for the program and its beneficiaries.9

The problem is that while the rates have been reduced, they are not reflective of a competitive market. Hundreds of economists have raised concerns since the initial implementation of the program about the methodology skewing the actual market forces to produce artificially low rates, as described in Sections III and IV. As shown in the illustrative example in that section, a combination of methodological steps artificially lowers the rates to levels that require half of the bidders to accept amounts that are less than what they bid or stop providing equipment and services in the competitive bidding areas.

Now the problem is even greater because these rates have been extended to the very areas the Congress indicated should not be subject to the competitive bidding program. In efforts to save Medicare $4.4 billion by the end of 2020, CMS has rolled these rates out nationwide to non-CBAs.10 While the Congress indicated that the Secretary could “use information”11 from the competitive bidding program to adjust the fee schedule amounts, it importantly did not authorize the Secretary to apply the competitive bidding rates to non-competitive bid areas. Yet, CMS has decided to do just what the Congress did not authorize. In half of those areas, the competitive bidding rates (from densely populated urban areas) are simply being applied without the 10 percent rural adjustment. While this adjustment is important, the amount selected is arbitrary and less than what data from the most efficient providers relying on economies of scale suggest the adjuster should be.

The problems can be fixed and without legislation. Section VI outlines immediate steps that the Administration can take to address the ongoing concerns and make competitive bidding a viable program that does not lead to beneficiary harm.

---

9Centers for Medicare and Medicaid Services. (2007). 42 CFR Parts 411 and 424 | Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues; Final Rule. (Federal Register, Vol. 72, No. 68)
11SSA 1834(a)(1)(F)(ii).
I. OVERVIEW OF COMPETITIVE BIDDING PROGRAM METHODOLOGY

While there is no question that the current methodology has reduced rates and Medicare spending, the current methodology promotes low-ball bidding and skews rates. It was designed to require CMS to engage in a series of complex calculations and adjustments to get to a rate that results in half of the winning bidders being forced to accept rates that are below what they bid.

The statute provides CMS with broad authority as to how it determined the CBP rate. It provides that: “Payment…shall be based on bids submitted and accepted.” Medicare uses a median / composite bid methodology for setting the CBP rate. The process includes a series of steps in the current process are represented in the following chart.

Figure 1. Current CB Methodology (Using Median/Mean)

Definitions:

- **Item Weight**: A number assigned to an item based on beneficiary utilization rates using national data.
- **Weighted Bid**: The item weight multiplied by the bid price submission for an item.
- **Composite Bid**: The sum of a supplier’s bids in a product category.

This process is much more complicated than it needs to be, lacks transparency, and as described in detail below results in the rates being set at amounts that are inconsistent with what the market price would be in relationship to the cost of providing the services. As many experts have described over time, the issues of non-binding bids, licensing, median price bids, composite bids,

12SSA § 1847(b)(5).
inability to find a clearing price, and a lack of transparency, taken together, lead to an arbitrary pricing scheme.

Although CMS has made some efforts to improve the program, these fundamental 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.\footnote{OIG, “INCOMPLETE AND INACCURATE LICENSURE DATA ALLOWED SOME SUPPLIERS IN ROUND 2 OF THE DURABLE MEDICAL EQUIPMENT COMPETITIVE BIDDING PROGRAM THAT DID NOT HAVE REQUIRED LICENSES” (May 2016).} In addition, CMS has noted the existence of “inversions,” which means that bidders are submitting irrational bids that result in the rates for certain items with additional product features to be lower than the rates for similar products without those features.\footnote{CMS “‘End-Stage Renal Disease Prospective Payment System, Coverage and Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program Bid Surety Bonds, State Licensure and Appeals Process for Breach of Contract Actions, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program and Fee Schedule Adjustments, Access to Care Issues for Durable Medical Equipment; and the Comprehensive End-Stage Renal Disease Care Model Final Rule” (November 2016).}

In addition to this methodology being used to set rates in CBAs, CMS has now applied it to the rest of the United States, with only about half of those locations – those defined as “rural” – receiving a 10 percent adjustment to acknowledge the fact that the rates were set using information from densely populated urban areas that may bear no resemblance to the areas in which the rates are now being applied. The rates in remainder of the non-CBAs are the unadjusted CBA rates.

II. EVIDENCE SHOWS COMPETITIVE BIDDING PROGRAM CREATING PROBLEMS FOR PATIENTS, HEALTH CARE PROFESSIONALS, AND SUPPLIERS

Since its inception, the CBP has been a political lightening rod. Supporters point to the substantial savings achieved – which were significantly more than the Congressional Budget Office (CBO) estimated – while opponents argue that the CBP has reduced access to medically necessary services. The savings have been easy to determine, but until now the true impact of beneficiaries has been more difficult to assess. As this section details, new survey data – including a recently peer-reviewed publication from the American Thoracic Society (ATS) survey of patients – detail the challenges patients, health care professionals, and suppliers face.

The CBP Makes It Difficult for Beneficiaries to Obtain the Equipment and Supplies They Need. Anecdotal evidence abounds suggesting that beneficiaries who need DME, and home respiratory therapy in particular, have experienced problems. As providers adjusted to the new lower rates, beneficiaries have had to contend with fewer services, reduced deliveries, limited interactions with respiratory therapists, and reduced service areas. In some instances, beneficiaries have lost access to important modalities, such as liquid oxygen, because providers simply cannot afford to provide the equipment and supplies necessary under the Medicare rates.
The Alpha-1 Foundation along with the COPD Foundation have repeatedly raised concerns about beneficiary access to liquid oxygen. The Alpha-1 Foundation has stated that CBP has inappropriately limited access to this important modality option for beneficiaries.\(^\text{15}\)

The widening elimination of liquid oxygen is rooted in a competitive bidding program that Medicare put into effect in 2011. The program, which has been expanding in phases across the country over the last five years, was intended to reduce the cost of home medical equipment and services, including wheelchairs, beds and oxygen. But it has also caused providers to nearly phase out liquid oxygen because they cannot pass the high cost of liquid oxygen to Medicare or the consumers.

This means that people with severe lung disease are seeing their liquid oxygen replaced with large compressed oxygen tanks. Those who use liquid oxygen to provide for their mobility are often unable to pull heavy compressed oxygen tanks around behind them, or to load up enough tanks in their vehicles so that they can breathe away from home for more than a short time.\(^\text{16}\)

Limitations on access to liquid oxygen can be particularly problematic because studies show that patient compliance in certain instances is higher for those using liquid oxygen when compared to those using with concentrators.\(^\text{17}\) The Clinical Director of the Alpha-1 Foundation, Dr. Robert Sandhu’s has sharply criticized the CBP directly.

Basically, it’s reached a crisis state. Patients, I believe, are suffering, and some may even be dying because of the Medicare policy. [CMS] say[s] their program is a huge success. They’re saving a lot of money. By instituting this competitive bidding, they’ve really cut down on the amount of money that they’re having to pay for oxygen, but they’re doing that at the expense of patients not being able to ambulate, and they’re also doing it at the expense of some patients probably becoming sicker or even dying because they can’t get the oxygen they need. Most oxygen companies nowadays have dropped liquid oxygen entirely from their inventory, so some patients that could only get sufficient oxygen when they’re outside the home by using a liquid system are basically not able to get the oxygen they need.\(^\text{18}\)

Measuring the Impact on Patients Has Been Difficult, Until Now. During the initial years of the Medicare CBP, the true impact of the drastic reduction in Medicare rates that occurred using the CBP methodology remained opaque for several reasons. First, during the early rounds


\(^{16}\)Id.


\(^{18}\)Id.
of competitive bidding many winning providers were able to accept the lower rates as part of an “experiment.” They viewed maintaining a presence in the market even at lower rates as better than being prohibited from providing equipment and services. Many naively hoped that the critiques of the program would persuade lawmakers to reform the system so that the rates would truly reflect market pricing.

Second, for some larger providers, the lower rates were offset by an increase in volume, as well as improved economies of scale, in the early years. As the rates continued to fall through subsequent rounds, however, their ability to cover their costs through increases in volume waned. Other providers were able to rely upon a cross-subsidization from traditional fee schedule rates in non-CBAs to offset the losses in CBAs.

Third, the competitive bidding contracts themselves prohibited providers from turning away patients. The regulations, contracts, and guidance documents all require winning providers to “agree to furnish items under its contract to any beneficiary who maintains a permanent residence in, or who visits, the CBA and who requests those items from that contract supplier.” The regulations further state: “Any deviation from contract requirements…constitutes a breach of contract.” This means that even if business judgment would dictate not providing services, these winning providers are required to do so. Thus, beneficiaries have been protected by these legal restrictions from experiencing access problems.

These requirements meant that it would be nearly impossible to meet the narrow definition of “access” CMS adopted. CMS has focused on unresolved complaints about beneficiaries not being able to obtain equipment and supplies, which given the contract and regulatory requirements is nearly impossible to meet. CMS also defined access in terms of the beneficiary complaints it received. However, as ATS has noted, there are serious concerns about the ability of beneficiaries to navigate the complex Medicare complaint process. “Less clear, yet important, is that patients with hypoxemic lung disease may experience frailty and fatigue that challenges their ability to navigate CMS’ complaints process and advocate for their needs.” ATS also reported that “70 percent of patients were unaware of the Medicare Ombudsman or COPD Info Line to report unresolved problems.”

CMS later added “assignment” as a way to assess the impact of competitive bidding rates. CMS has claimed that the fact that providers continue to accept assignment (and not bill beneficiaries

---

19 42 C.F.R. §414.422(e)(1); see also CB contract Article V: Furnishing Items; see also Contract Supplier Obligations Fact Sheet.
20 Id. at §414.422(g)(1).
22 See supra, note 1.
24 Id. at 16.
above the Medicare rate) means that the Medicare rates are sufficient. This is not true for two important reasons. First, assignment is mandatory in CBAs. Second, in non-CBAs, the question is more complicated than it may first appear. If a supplier does not agree to assignment, it must collect payment from patients each month. In light of their experience with copayments, suppliers are extremely reluctant to seek the entire payment from patients who historically may not always pay their 20 percent copayment share. By accepting assignment, a supplier receives at least 80 percent, even if the rate is inadequate. In addition, non-assignment is not permitted for dual-eligibles, which comprise a substantial portion of home respiratory therapy patients.

Most recently, CMS has suggested that it is monitoring a large number of quality outcome indicators that show no change in beneficiary outcomes as well. However, as The Moran Company 2018 analysis of 2016 data show, this assertion simply cannot be true. The Moran Company analyzed 2016 CMS claims data and confirmed that COPD beneficiaries incur more health care costs than other beneficiaries. Most interestingly, newly-diagnosed COPD patients who start oxygen therapy within two months of first diagnosis have total health care costs downstream of that diagnosis that are about 20 percent lower than those who start oxygen later. This finding raises the policy concern that patients who delay oxygen therapy due to access problems in the early stage of treatment may generate health system costs that are materially larger than whatever savings CMS may be achieving via payment cuts.

Moreover, in the case of beneficiaries with COPD the assertion that there has been no negative impact on patient outcomes is not consistent with CMS’s own hospital quality data. While CMS data show no change in the outcomes reviewed, it is notable that at a time when mortality, admissions, and emergency room visits are declining for other Medicare populations they are not declining at the same rate in the COPD population, despite the significant incentives that CMS put in place to improve these outcomes. Rather than indicate that the cuts are having no effect, it appears that the cuts are destabilizing the home respiratory therapy suppliers to the extent that it is making it difficult to improve health outcomes for COPD patients. Additionally, the ATS study finds that beneficiaries have experienced isolation and inactivity, two critically important quality of life aspects that CMS has not addressed in its statements.

As the ATS survey also recognized, patients are reporting problems with their oxygen equipment, not having their oxygen saturations tests when oxygen is delivered, and not having access to licensed respiratory care practitioners in the home. The LAM Foundation found similar problems in its survey from 2014, as did the Pulmonary Hypertension Association. As ATS writes:

---

25 See supra, note 1.
26 The Moran Company available upon request.
27 See supra, note 1.
28 Supra note 23 at 15.
29 Id.
30 Id.
While these reductions in many cases do not mean that Medicare beneficiaries no longer receive medically necessary equipment and supplies, it does mean that they do not receive the level of services they and their families received prior to the rates dropping below the cost of providing services.  

The actual impact of the implementation of the CBP using a methodology that lowers the rates below what the market would establish is real and much more prevalent than the picture drawn by statements from CMS. These problems more than justify the need to immediately reform the competitive bidding methodology to address long-standing concerns, as well as to provide interim payment increases in the non-CBAs where the modified fee schedule that applies CBP rates are being used.

A. PATIENTS EXPERIENCE PROBLEMS UNDER COMPETITIVE BIDDING PROGRAM

Despite the collection of beneficiary concerns by patient advocates, such as the COPD Foundation, the Alpha-1 Foundation and others, as well as stories collected by providers across the country, it has been challenging for some federal policy-makers to recognize that beneficiaries were experiencing real problems. The recent release of a peer-reviewed survey conducted by ATS supports the previous collection of concerns and echoes other independent organizations who have raised concerns about the negative impact of the CBP on Medicare beneficiaries.

There is no stronger statement as to the correlation between beneficiary harm and the rates resulting from the current CBP methodology than the following one from the authors of the ATS study in October 2017:

Consequently, CMS beneficiaries are affected by economic decisions from the federal Competitive Bidding Program (CPB) that determines reimbursement for their durable medical equipment (DME).  

As the ATS and other studies by the LAM Foundation and the Pulmonary Hypertension Association recognize, access should not be defined only as beneficiaries’ complaints not being resolved or high level, rather than granular, quality indicators remaining flat. Access should also include the following:

- Having an adequate number of providers in a service area that provides patients with actual choice among suppliers.
- Experiencing the same or similar trends in key quality indicators that other Medicare beneficiaries or commercial insurance patients are experiencing.

---

31 Id.
32 Id. at 4.
Establishing service areas that allow for 24-7 care and response to beneficiaries needs and that such areas are not reduced as payment rates are cut.

Providing the full range of services, including access to licensed respiratory care practitioners, required for quality treatment and not having those services reduced as payment rates are reduced.

Ensuring that beneficiaries diagnosed with COPD or other similar diseases receive the home respiratory therapy they require as the disease progresses.

The 2017 ATS study found several indications of patient harm that do not fit the narrower views used by some policy-makers. First, the study found that patients receiving home oxygen therapy have a reduced quality of life. This harm can be measured in terms of the lack of mobility, as well as the experience of isolation and inactivity. “While isolation and inactivity are not generally measured health outcomes, they are clearly documented by this survey’s results as a negative impact from limited current portable oxygen options.” Other studies have shown that 45 to 70 percent of patients with COPD require long-term oxygen therapy for 15 or more hours per day. Arnold et al found that patients’ quality of life suffer dramatically if they do not have the appropriate equipment, lack appropriate individualized instruction from qualified individuals, fear “running out of oxygen,” or dislike how their equipment looks and performs in public. The authors of the ATS survey concluded that:

If reimbursement constraints continue to impact oxygen suppliers, patients’ access to adequate portable oxygen systems will continue to be affected. The disappearance of liquid oxygen, the inability to provide adequate portable systems, and the limitations on extra tanks and batteries inhibit patients’ mobility, exercise, socialization, travel, and work.

Patients, including Medicare beneficiaries, want to be able to move around and continue to engage actively in life. When they are asked what they would change to improve their experience, they most frequently respond by having access to more portable tanks/supplies “so I can leave home more frequently and for longer periods of time,” having access to portable equipment so they can travel, and reducing wait times for service requests or supply delivery.

---

33 Id. at 14 & 18.
34 Id. at 17.
37 Supra note 23 at 17.
38 Id. at 11.
Patients’ ability to access such services is directly linked to the rates providers receive and the ability of these rates to cover the cost of providing such services more frequently. When equipment and supplies are limited, beneficiaries experience more isolation and inactivity because of limited current portable oxygen options. As ATS notes, this situation leads to adherence problems. “Data exists that poor adherence to prescribed oxygen is associated with higher use of healthcare resources.”

While CMS has indicated it has not received complaints from beneficiaries, ATS found that “half of respondents reported problems with their oxygen; with an estimated 1-1.5 million U.S. oxygen users the potential impact is enormous.” 65 percent of respondents did not have their oxygen saturations tested on their delivered equipment, which ATS attributed to the lack of resources that would have otherwise allowed providers to use licensed respiratory care practitioners in the home setting. The authors of the study also questioned whether beneficiaries could actually navigate the CMS complaint process and advocate for themselves so as to obtain what they needed.

These results are not surprising to anyone who has followed the implementation of the CBP since 2011. As the ATS notes in its paper, the LAM Foundation found in 2014 that 33 percent of the oxygen users it surveyed had problems obtaining oxygen. The Pulmonary Hypertension Association surveyed patients on supplemental oxygen and found that more than 60 percent experienced service problems, including waiting more than five days for equipment to arrive, missing supplies, and/or have misinformation or no support with regard to traveling with DME.

The American Association of Diabetes Educations has also conducted multiple surveys and found that:

As a result of the CBP, Medicare beneficiaries have fewer choices and limited access to the DTS most commonly used before implementation of the CBP. As a result, beneficiaries who chose to obtain their DTS through mail-order suppliers are effectively being made to either switch to different DTS or purchase DTS through non-mail-order settings. As previously noted, switching to unfamiliar or unsuitable DTS can carry health consequences. This study also demonstrates that the information available from suppliers themselves is inconsistent and may be further complicating Medicare beneficiary's ability to find appropriate DTS.

Another study conducted by the National Minority Quality Forum assessed the impact of the CBP on beneficiary acquisition of diabetic testing supplies. This peer-reviewed retrospective,

39 Id. at 17.
40 Id. at 15.
41 Id.
42 Id. at 17.
43 Id. at 13.
longitudinal analysis found that the CBP program is “causing confusion among beneficiaries with diabetes, increasing the rate and costs of hospitalization for these beneficiaries and putting their lives at risk.”

A 2015 study by the same group also found:

clear evidence that the CMS’s monitoring of CBP safety is inadequate, making it difficult to determine from CMS’s safety monitoring whether the CBP is producing higher costs for the Medicare program by raising hospitalization rates, causing longer inpatient stays, and increasing mortality among millions of beneficiaries.

This evidence included beneficiaries having more difficulty acquiring supplies, increased hospital admissions, and higher mortality rates. It also noted:

Although our analysis has focused primarily on diabetes-testing supplies, one can assume that similar disruptions were experienced across the other product categories, as indicated in CMS reports from pilot studies in Polk County, FL (oxygen supplies), and San Antonio, TX (oxygen supplies, general orthotic devices, hospital beds and accessories, nebulizer inhalation drugs, manual wheelchairs and accessories), and by anecdotal evidence.

While more work can and should be done this area, these studies show that access to home respiratory therapy cannot be adequately assessed by looking at unresolved beneficiary complaints or assignment rates. Patients’ access to services and trained personnel, delivery areas, and quality life must also be considered. Outcomes should be improving, not simple viewed as positive if unchanged over time, especially when other providers are being incentivized to improve such outcomes. In short, many researchers and experts have identified problems that beneficiaries are experiencing as a result of the CBP and modified fee schedule. These results should not be ignored.

B. HEALTH CARE PROFESSIONALS EXPERIENCE DIFFICULTIES GETTING EQUIPMENT FOR PATIENTS UNDER COMPETITIVE BIDDING

47 Id. at iii.
48 Id. at 12.
49 Id. at 16.
Health care professionals are also identifying problems linked to the rates established under the CBP. While those supporting and opposing current policies often share anecdotal data to try to “prove” their contention, we know that such information is less than ideal when it comes to evaluating a program. However, the number of examples of health care professionals experiencing problems should not be ignored simply because there has not been sufficient time or resources to implement the most rigorous of studies. That is especially true when these stories align with concerns expressed by patients, analyses of Medicare data, and peer-reviewed literature.

One example proves illustrative of the problem. In 2017 a patient in rural Virginia could not be discharged when appropriate because there was no local home respiratory therapy supplier willing to add a new Medicare beneficiary after the rates has been cut to those in competitive bidding areas. Some of the suppliers that had provided services in this rural part of the State had closed their locations and stopped providing home oxygen therapy equipment and services to patients in that area. This patient’s discharge was delayed by several days because there was no local supplier willing to accept a new patient at the lower rates. Only after a provider was “incentivized” to provide the equipment and services was the patient able to obtain the home respiratory therapy equipment, supplies, and services needed to return home.

Health care professionals have been raising concerns from the earliest days of the CBP. In 2012, a pediatric pulmonologist and sleep specialist at Children’s Hospital Boston voiced in The New York Times serious concerns about the CBP not taking into account that some patients require extra care and time. While this time would lead to fewer hospitalizations that cost more, the physician worried that because the CBP does not account for differences in patient acuity, there would be “no incentive to do a better job of making sure the equipment is being used properly. And that, in turn, will lead to poorer outcomes.”

He also warned: “[i]f competitive bidding is predicated on supplying equipment at the lowest possible price, something has to give. And more likely than not, that something will be patient care.” As described in the ATS report and reported by CMS, patient outcomes are not improving for beneficiaries who rely on DME in the same way as they are for those living with other chronic conditions who do not rely on DME.

While it is true that this is only one example, it is one of many. During the summer of 2017, Dobson & DeVanzo surveyed hospital discharge planners/case managers across the country, asking them about whether or not they experienced problems when seeking medically necessary DME for Medicare beneficiaries. While this survey used social media as a primary means for gathering information quickly and has not yet been peer reviewed, it does document the concrete existence of specific access problems downstream of the implementation of the CBP, as well as extending competitive bidding rates to non-competitive bidding areas with little or no adjustment.

Specifically, the survey found:

50 Dennis Rosen, “When Competitive Bidding Hurts Patients” (May 15, 2012).
51 Id.
Case managers are experiencing a wide range of quality and access issues, and many suppliers are strained to the point where beneficiaries question their capability to meet their needs.

- 88.9 percent of case managers report an inability to obtain DME and/or services in a timely fashion
- Case managers reported difficulties in locating suppliers to provide DME and services, resulting in unnecessary medical complications and expenses.
  - This was reported to be especially troubling for beneficiaries who receive oxygen therapy with 74.3 percent reporting some sort of disruption to their service.
- Case managers noted that the program has complicated the discharge process and that delays in obtaining DME have often resulted in or contributed to Medicare beneficiaries' need for emergency care or a hospital re-admission.
  - 70.8 percent of case managers report discharge delays of 1-7 days
  - 61.7 percent of case managers say patients are having medical complications some of which result in readmission to the hospital.

Even though more rigorous studies can and should be done in this area, there is no question that a substantial number of health care professionals assisting patients being discharged from hospitals and requiring DME are experiencing problems. This significant trend should not be simply discounted.

C. SUPPLIERS EXITING MEDICARE BECAUSE OF COMPETITIVE BIDDING

The problems beneficiaries and health care professionals are experiencing is due in large part to the simple fact that the number of suppliers is decreasing. While many smaller suppliers are leaving the business, the large regional and national companies are decreasing their participation in the Medicare program by stopping services in some States, closing and/or consolidating locations, and laying off thousands of employees as well. These closures reduce patient choice, service areas, and the timeliness of providing services.

Using data from 2013 – 2017 Noridian (PDAC) Freedom of Information Act “Data on Suppliers with Specific Supplier Type Codes, VGM found between 2010 and September 2017 a 22 percent decrease in the number of suppliers using durable medical equipment supplier type codes, excluding orthotics, prosthetics and pedorthics.\(^{52}\) Using Medicare “Supplier” Enrollment Data, VGM found an overall decrease of 8.1 percent in the number of suppliers with PTANs.

---

\(^{52}\)Mark J. Higley, Vice President Regulatory Affairs VGM, “DMEPOS Supplier Analysis: Medicare Enrollment Trends - 2013 to Present” (September 27, 2017).
The study also found that in the 10 most populous states, where competitive bidding is focused, there was a 47 percent reduction in the number of HME suppliers over three and a half years.

In the fifteen lowest population states, where competitive bidding was largely absent, there was an 18 percent reduction in suppliers over the same period.
The significant decrease in the number of DME suppliers coincides with the implementation of the competitive bidding rates and the extension of those rates to non-competitive bid areas.

While these data alone may not distinguish between suppliers leaving a market entirely versus consolidation or establish a direct correlation between payment rates and reduced capacity/access issues, the significant difference between 2010 and 2017 is a trend that should not be easily dismissed.

The members of the two national trade organizations who work in these areas know first-hand that many suppliers are in fact closing their doors. As described below, the large national home respiratory therapy suppliers may be acquiring a company on occasion, but have certainly not expanded to the degree necessary for federal policy-makers to assume that these national companies have absorbed the capacity of the organizations that have closed. In fact, these larger organizations are reporting that they too are reducing their service areas and closing branches in areas where the Medicare rates make it impossible to cover the cost of providing services in those areas.

Although consolidation in other areas of health care has been viewed positively because it increased efficiencies and reduced the number of suppliers generally making oversight of their activities easier, the significant change in DME providers in a relatively short period of time should be of great concern, especially in areas that are under-served. Patient choice is being limited. In terms of home respiratory therapy, that limitation is not only as to the choice of the provider but also about the ability to access liquid oxygen.

When analyzing the 2014 and 2015 Durable Medical Equipment Public Use File (DME PUF) (the most recently available public data), The Moran Company found that in just under 45 percent of rural areas, Medicare beneficiaries have access to only one or two home oxygen therapy providers. In 2015, there were 36 rural ZIP codes that had no supplier with an NPI billing Medicare.\(^5\)

While it could be true that some provider outside of these ZIP codes may still provide services, it is becoming less likely. That is because many providers are limiting their service area and reducing deliveries, especially in rural areas that require traveling substantial distances. These percentages are similar to those cited by critics of the Affordable Care Act who state that having only one or two plans in a county means that Americans do not have sufficient access to coverage.\(^5\) Given the need for a physical presence to provide 24-7 services in a timely manner, the same concern should be attached to the availability of home oxygen providers in rural areas. These data predate the Modified Fee Schedule and strongly suggest that most beneficiaries already did not have a choice of suppliers where they live.

---

\(^5\)The Moran Company (2017) available upon request.

In addition, members of the CQRC, which include the largest national and regional providers of home respiratory therapy equipment, supplies, and services, are reporting closures and changes in service that support the conclusion that the reduction in suppliers is not due to efficiencies driving consolidation in a healthy manner, but rather because of inadequate funding to maintain business that are dependent on the Medicare rates. For example:

- In mid-June 2017, a large regional supplier announced that it would no longer provide services in California, New Mexico, and Oklahoma.

- One national home respiratory supplier has closed 87 locations in non-CBAs, 44 locations in CBAs, and has laid-off 3,000 people since the implementation of the Modified Fee Schedule.

- Another large supplier has closed nearly 200 locations in non-CBAs.

- At least one national supplier has reduced or stopped providing services in rural areas in 24 states.  

Attrition in CBAs is also occurring and troubling because even the most efficient suppliers – the national and larger regional companies are closing locations in these areas. For example:

- Since the beginning of the competitive bidding program, one large national company has closed 44 locations in CBAs.

- Another large national company has closed 185 branches in CBAs since the beginning of the program, with 97 of those closures occurring in 2016 and 2017. More closures are planned for 2018 and 2019.

- Yet another national company has closed 84 locations in CBAs and across all CBAs and non-CBAs had to let go more than 1,000 employees.

The ATS peer-review study drew a correlation between the reimbursement rates, reduced number of suppliers, and patient access. It specifically stated:

[I]f reimbursement constraints continue to impact oxygen suppliers, patients’ access to adequate portable oxygen systems will continue to be affected. The disappearance of liquid oxygen, the inability to provide adequate portable systems, and the limitations on extra tanks and batteries inhibit patients’ mobility, exercise, socialization, travel, and work.  

---

55These States include: Oregon, Arizona, New Mexico, Wyoming, Montana, Texas, Colorado, Missouri, Iowa, Kansas, Nebraska, Wisconsin, Indiana, Kentucky, Tennessee, Arkansas, Louisiana, South Carolina, Virginia, Pennsylvania, Upstate NY, New Hampshire, Vermont and Maine.

56See supra note 23 at 17.
HME News conducted an informal survey of suppliers in April 2017, asking providers to share how their businesses have been impact by the national roll out of competitive bidding rates to non-CBAs. A majority reported closing locations and laying off significant percentages of employees. Some have eliminated specific product options in non-CBAs, where CMS cannot require them to maintain specific products. Many also reported reducing the time their teams are able work directly with patients and spend time in the home. Others reported leaving the Medicare program and no longer accepting Medicare patients, offering equipment and services only to individuals who have commercial insurance or are willing to pay out of pocket.\(^{57}\)

Even though some federal officials have dismissed the reduction in suppliers, Medicare beneficiaries are concerned. The ATS reported:

> When asked what “one thing” they would change to improve their oxygen experience, the most frequent response was “more portable tanks/supplies so I can leave home more frequently and for longer periods of time” (17%), followed by “providing a POC when I travel”, and “service/check equipment on a regular basis”. Almost half (40%) noted waiting for servicing requests or supply deliveries.\(^{58}\)

These beneficiary concerns align with the decision of Medicare providers to reduce their service area, staff, and locations. While these reductions in many cases do not mean that Medicare beneficiaries no longer receive medically necessary equipment and supplies, it does mean that they do not receive the level of services they and their families received prior to the rates dropping below the cost of providing services.

**E. SUMMARY OF THE NEGATIVE CONSEQUENCES OF THE CURRENT CBP**

The flawed methodology of the CBP has led to low-ball bidding and skewed rates that are below the cost of providing equipment and services to Medicare beneficiaries. While the majority of beneficiaries continue to receive equipment, the modality, number of supplies, frequency of deliveries, access to trained health care professionals, and other services has substantially deteriorated.

Hundreds of providers have closed their doors and others no longer accept Medicare beneficiaries. Other providers are limiting their service areas. One way of limiting costs is limiting the delivery area. Some home respiratory therapy suppliers have stopped delivering beyond a certain area and require beneficiaries to pick up their equipment and supplies, especially if patients request supplies that are more frequent that the normal distribution cycle. For example, one supplier will no longer deliver equipment or supplies outside of a 30-mile radius from a branch location.

\(^{57}\)http://www.hmenews.com/blog/what-has-been-impact-national-roll-out-competitive-bidding-pricing

\(^{58}\)See supra note 23 at 11.
Because the rates in CBAs and non-CBAs is lower than the cost of providing services, on average, the vast majority of providers that continue to work with the Medicare program have reduced the services they provide to beneficiaries. Such limitations include:

- Providing services immediately upon a patient’s request
- Delivering home oxygen to rural areas, meaning that patients must go to a branch location to pick up the equipment and/or supplies
- Access to respiratory therapists
- Off-cycle deliveries of portable oxygen
- Care coordination services, such as coordination with hospital discharge planners

As a result of these changes, beneficiaries are experiencing stagnant health care outcomes and experiencing more isolation and inactivity. These problems lead to lower patient compliance as well. Clinical data about compliance with therapy also suggests they are or will be visiting emergency departments more often and being hospitalized more frequently. “Data exists that poor adherence to prescribed oxygen is associated with higher use of healthcare resources.”

Lack of compliance and access to specialized home visits by trained staff has been shown to decrease survival.\(^{59}\)

The use of greater resources and more frequent hospitalizations is at odds with the overarching trends experienced by Medicare beneficiaries with other chronic diseases. For example, there has been a steady decline in admissions, mortality, and morbidity among patients living with End Stage Renal Disease in recent years.\(^{61}\) CQRC members have also reported reductions in hospitalizations experienced by COPD patients in the commercial market. Yet, as The Moran Company found in its analysis of 2016 CMS data, COPD patients in Medicare are being hospitalized more frequently when there is a delay in their ability to access home respiratory therapies.\(^{62}\) Moreover, CMS reports that these quality indicators have remained unchanged for beneficiaries who rely upon home respiratory therapies.\(^{63}\)

The lack of progress in this area is likely the result of a “perfect storm” – home respiratory therapy rates have been inappropriately cut year-over-year, while the cost of complying with Medicare documentation requirements has substantially increased. These documentation-related costs can be 40 percent or more of the cost of caring for patients. At the same time, these suppliers are excluded from participating in innovative payment models.

III. COMPETITIVE BIDDING PROGRAM IS HARMING PATIENTS BECAUSE IT SETS RATES BELOW COSTS


\(^{60}\)Id. at 15.


\(^{62}\)See The Moran Company (2017) available upon request.

\(^{63}\)See supra note 1.
The concept of CBP is laudable, but the problems highlighted above are occurring because the current methodology leads to skewed rates that do not reflect market costs. During the past several years, the CQRC has sought to work with the federal government to fix the underlying problems, which an analysis of member company data has also highlighted. To understand the relationship between the cost of providing home respiratory therapy services compared the rates created under the CBP, the CQRC members aggregated their data using the tool based upon the principals CMS uses for its own Medicare cost reports. An analysis of the data collected showed that the cost of providing services in competitive bidding areas (CBAs) was on average 5 percent greater than the actual CBP rates. It also showed that the cost of providing services in non-CBAs was on average 13 percent higher than the costs in non-CBAs.64 These results demonstrate that even the larger, national and regional organizations were unable to cover the cost of providing services under the rates using the current CBP methodology.

The CBP Skews Rates Below Market Costs. As described below, there are five reasons that account for this problem, which align with the concerns that experts have identified with the current CBP methodology. They are:

- Using a median rather than a clearing price to set the rate. The use of a median (which is the middle bid amount when all of the bids are arrayed lowest to highest) means that half of the suppliers who are offered bids are required to accept rates that are actually lower than the amount that they bid. This methodology distorts the rate and divorces it from the amount at which the market would actually set the rate.

- Using a composite bid to determine the rate. CMS defines a composite bid as “the sum of a supplier's weighted bids for all items within a product category for purposes of allowing a comparison across bidding suppliers.”65 This process allows entities that may have no intention of providing service products to bid extremely low amounts that then lower the composite bid. When the composite bids are arrayed, these low-ball bids push the pivotal bid and ultimately the rate lower than what the market would have set the price at.

- Using bids and projected capacity from suppliers without experience providing equipment and services in the CBAs. Another way the rates are depressed is through the use of bids and projected capacity when the rates are set. Bidders that have never provided equipment and services in a particular product category in a specific CBA will not have sufficient experience to bid an amount or project a capacity that accurately reflects the market. While it is important to include bidders in the process and make sure they have the opportunity to win a contract, their information should not be used to set the rate because it is likely to inappropriately skew it.

- Combining home oxygen and home sleep equipment and services into a single product category. The CBP rates for home respiratory therapies is also depressed below what

---

64 CQRC, “Comparison of Costs in Competitive Bid and Non-Competitive Bid Areas” (May 2015).
65 42 CFR §414.402.
would otherwise be the market price because home oxygen and home sleep equipment and supplies are included in the same product category. This means that suppliers that want to provide sleep therapy only can bid oxygen products at a substantially lower amount than actual costs because they do not intend to provide the oxygen products.

Audits Are a Complicating Factor. The current documentation requirements and audit process that DME providers generally and home respiratory therapy providers more specifically, must endure are a complicating factor that has also increased the cost of providing services, while the CBP has depressed reimbursement rates. Documentation requirements and audits have substantially increased the cost of providing equipment and services to Medicare beneficiaries. In addition, the current focus on documentation errors detracts from efforts to actually monitor for and stop fraudulent behavior by unscrupulous entities.

Current data show that there actually very little fraud in the home respiratory therapy space. CMS data shows that the vast majority of home respiratory therapy equipment and services are medically necessary. According to the 2016 CERT report, the improper payment rate for home oxygen therapy was 45 percent. Of that, 91.2 percent was due to missing documentation only 0.3 percent was due to the beneficiary not meeting the medical necessity requirements. For CPAP (Continuous Positive Airway Pressure) equipment, the improper payment rate was 59.6 percent. Of this percentage, 85.2 percent was due to missing documentation, but only 0.6 percent was due to an actual lack of medical necessity.

If CMS's own contractor acknowledges that nearly 100 percent of beneficiaries who are prescribed home respiratory therapy actually meet the medical necessity requirements, it is not clear why claims should be denied. The current overly technical and burdensome documentation requirements serve no purpose.

Yet the government and suppliers remain engaged in an expensive and time-consuming appeals process because of the focus on prescriber medical records. Common sense reform is needed to bring balance to the system and reduce the cost of providing equipment and services to beneficiaries.  

---

66The CQRC has supported various options for putting patients over paperwork in this system. Most recently, it recommended that CMS:

1. Use its discretionary authority to remove home respiratory therapy equipment from the face-to-face examination (returning to the physician visit requirements in the original Local Coverage Determination (LCD) and the written order prior to delivery requirements (returning to previous requirements related to written orders), which is from where the burdensome and costly documentation requirements stem. If this change cannot be implemented quickly, CMS could:

   a. For home oxygen therapy, rely upon the Certificate of Medical Necessity (CMN) to establish that a face-to-face visit occurred, rather than requiring patients' medical records, and to allow the CMN to constitute a valid written order for purposes of dispensing home respiratory therapy equipment so long as it includes the detailed written order elements and the date of the physician visit.


IV. PAYMENT POLICY EXPERTS AND ECONOMISTS CRITIQUE OF METHODOLOGY EXPLAIN WHY PROBLEMS ARE OCCURRING

In 2016, The Moran Company reviewed the policy environment surrounding Medicare reimbursement for DME under the CBP. In its report entitled “The State of Expert Judgment Regarding Medicare’s Competitive Bidding Program for Durable Medical Equipment,” it reviewed 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 product nationwide. In sum, the report found:

- 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. While recent statutory changes implement greater penalties for not accepting a contract, this process does not actual bind a supplier to its bid.

  - 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

b. For home sleep therapy, rely upon the required prescriptions and sleep test results to constitute a valid written order for the purpose of dispensing home respiratory therapy equipment so long as these documents include the detailed written order elements and the date of the physician visit.

2. Modify the proof of delivery requirement to allow for alternative documentation options; and

3. Streamline the audit process to avoid duplicative audits of the same patient with a different date of service

Implementing common sense reforms would reduce the burden on providers, health care professionals, and CMS, freeing the Agency and its contractors from focusing on red tape requirements and instead policing for actual fraud and abuse of the system. These savings could then translate into lower costs for providing services to beneficiaries and create a more efficient system. With an appropriate competitive bidding methodology, the Medicare rates could finally be stabilized and aligned with the initial goals of the program.
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.

- 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 CBP outlined in The Moran Company 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.

Other experts have consistently raised concerns. Most notably among the experts who have raised concerns about continuing to use the current CBP methodology is Tom Bradley of the Congressional Budget Office.

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.\textsuperscript{67}

In addition, several economists raised serious concerns that predicted the problems recent studies and analyses have shown. In 2010, a group of 167 economists, computer scientists, and other professionals wrote to then House Ways & Means Health Subcommittee Chairman Pete Stark (D-CA) raising four problems with the CBP. They are: (1) the lack of enforcement of the actual amounts bid; (2) the failure to use a clearing price methodology to establish the rates; (3) the use of composite bids (average of a bidder’s bids across many products weighted by a government-established demand); and (4) the lack of transparency. The group also raised concerns about the lack a clarity around quality standards and performance obligations. These experts predicted that the flawed methodology would lead to low-ball bidding, over- and under-estimation of actual demand for specific products, bid skewing, and suppliers selectively filling orders.\textsuperscript{68}

A similar group of 244 experts sent a similar letter to President Barack Obama the following year (2011), raising concerns that CMS has not acted to address the previous letters concerns and recommendations. This letter reports on simulations of the CMS methodology and a methodology that more closely followed the recommendations identified in the first letter. The results of these simulations were clear – the CMS methodology was inefficient, exhibiting efficiencies well below 50 percent. The experts warned that unless changes were made, the program would not achieve the goals of having beneficiaries receive quality goods and services they need and the taxpayers paying the least-cost sustainable price for these goods and services.\textsuperscript{69}

The process for setting rates is onerous, including multiple steps, many of which lack transparency, and that result in rates that are artificially low. To help members understand the impact of the methodology on determining the CBP rates, the CQRC with assistance from The Moran Company developed the following illustrative example.

In this example, the bid amounts and capacity amounts for oxygen concentrators were held constant and the different methodologies applied. As the chart in Appendix A shows, the current methodology which uses composite bids and the median methodology along with projected capacity results in a median rate of $90.46/month. Using the same bid amounts and actual capacity while applying the clearing price and a percentage off of the fee schedule (the CQRC recommendations described in detail in the next section), the rate is significantly higher. It is $126.64/month.

This difference has nothing to do with bid amounts or supplier costs. It is simply the result of the methodology selected to establish the rate. This example shows that the methodology is driving the price, not the bids.

\textsuperscript{67}“Medicare Auction Conference: Final Panel: What Have We Learned?” (University of Maryland, April 1, 2011), http://www.cramton.umd.edu/papers/health-care/.
\textsuperscript{68}D. Abreu, et al. Letter to Chairman Pete Stark (Sept. 26, 2000).
\textsuperscript{69}D. Abreau, et al. Letter to President Barak Obama (June 11, 2011).
It is the methodology driving the rates. As the chart below shows, the median methodology using composite bids results in half of the winning bidders to accept rates that are lower than what they bid. This system is not sustainable.

**Figure 2. Comparison of CBP Methodologies**

<table>
<thead>
<tr>
<th>Bidder</th>
<th>Composite Bid</th>
<th>Projected Capacity</th>
<th>Pivotal Bid</th>
<th>Bidder</th>
<th>Offered Contract</th>
<th>Bidder</th>
<th>Array Bids</th>
<th>Median (SPA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>124.63</td>
<td>25</td>
<td>9</td>
<td>Yes</td>
<td></td>
<td>9</td>
<td>79.6</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>133.13</td>
<td>27</td>
<td>4</td>
<td>Yes</td>
<td></td>
<td>4</td>
<td>85.03</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>141.64</td>
<td>20</td>
<td>3</td>
<td>Yes</td>
<td></td>
<td>3</td>
<td>90.46</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>150.14</td>
<td>20</td>
<td>7</td>
<td>Yes</td>
<td></td>
<td>7</td>
<td>95.89</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>155.8</td>
<td>20</td>
<td>6</td>
<td>Yes</td>
<td></td>
<td>6</td>
<td>99.51</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>164.29</td>
<td>20</td>
<td>2</td>
<td>No</td>
<td></td>
<td>2</td>
<td>99.51</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>175.63</td>
<td>44</td>
<td>10</td>
<td>No</td>
<td></td>
<td>10</td>
<td>99.51</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>178.46</td>
<td>32</td>
<td>5</td>
<td>No</td>
<td></td>
<td>5</td>
<td>99.51</td>
<td></td>
</tr>
</tbody>
</table>
As a result, the CBP creates an enormous burden on suppliers and threatens the quality of care provided to beneficiaries by subjecting them to rates that are inadequate. While national companies, like the CQRC members, were able for many years to “make it work” because of the cross-subsidization with rates in the non-CBAs, the decision by CMS to extend the competitive bidding rates (the Single Payment Amounts or SPAs) nationwide has pushed suppliers to the point of no longer being able to sustain taking care of Medicare beneficiaries.

With rates that are lower than the amounts at least half of the suppliers bid and that do not align with the cost of providing services to beneficiaries, the majority of suppliers are no longer able to cover the cost of providing equipment, supplies, and services in non-CBAs. They are having difficulty maintaining a physical presence in the market, which is necessary for home respiratory therapy suppliers to provide access to respiratory therapists and health care professionals to visit patients in the home.

Medicare rates should be set using a methodology that aligns with the intent of the CBP, which was to allow the market to 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. Unfortunately, the market forces are being skewed because of the methodology used to set the CBP rates, which threatens to make it impossible to achieve the other goal of the CBP to ensure that beneficiaries maintain access to high quality services provided by accredited suppliers.

V. RECOMMENDATIONS TO ADDRESS PROBLEMS AND MAKE COMPETITIVE BIDDING WORK

There are five solutions to this problem that do not require legislation and that would allow market forces to function as the Congress had intended when it authorized the CBP. Quite simply, CMS should follow the recommendations of the experts who have suggested that it use a clearing price methodology to establish CBP rate. This would ensure that no supplier is asked to accept (now required under the binding bid law) to accept a rate that is below the amount it bid.

Because clearing prices involve a single product, CMS would need to find a way to allow suppliers to bid on a single product. To avoid an impossible situation, CMS could have suppliers bid a percentage discount off of the 2015 DMEPOS Fee Schedule rates (as updated annually using the CPI-U). The product in this case is the discount. This method allows CMS to
compare the percentage off bids without having to create a composite rate. This methodological change would address concerns about transparency, as well as create a process that will be driven by market forces. The Agency has already indicated it will retain the 2015 Fee Schedule, updating it annually, to implement the bid ceiling policy, so there would be no additional work for CMS on that piece as well. With the Fee Schedule amount being the base, the rate for each product would be calculated using the percentage discount that meets the clearing price.

To address the problem of low-ball bidders, CMS could take two additional critical steps. First, it could separate home oxygen and home sleep therapy into two distinct product categories. Second, it could set the clearing price using the actual capacity of bidders. This means that if a supplier has no experience in a product category in a CBA, then its bid would not be used to set the clearing price. However, if its bid is at or below the clearing price it would be offered a contract.

Figure 3. Applying CQRC Recommendation of Clearing Price (assumes no other changes)

CMS currently has sufficient authority to adopt these changes prior to the next round of competitive bidding. Doing so would bring needed transparency to the CBP and simplify the cost and burden on both the industry and the Agency.