MEDPAC Medicare Payment Advisory Commission

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June 28, 2006

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Box 8013
Baltimore, Maryland 21244-8013

RE: file code CMS-1270-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled: *Medicare program; Competitive acquisition for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and other issues.* [CMS-1270-P] Federal Register, May 1, 2006. We appreciate your staff's ongoing efforts to administer and improve the payment system for durable medical equipment, prosthetics, orthotics, and supplies, particularly considering the agency's competing demands.

We support the use of competitive bidding in the Medicare fee-for-service program for DMEPOS. By giving suppliers an incentive to offer prices close to their costs, competitive bidding has the potential to give CMS better price signals for rate setting and to improve the value of beneficiary and program spending. Your final report on the competitive bidding demonstrations noted that they generated substantial savings without adversely affecting quality or access.

We note that the proposed rule pays due attention to the need for transition policies and for ongoing monitoring of access and quality. Transition policies, for example, those in the proposed rule allowing some beneficiaries to maintain established relationships with some suppliers who do not win contracts, will be important to minimize disruption for beneficiaries. The proposed rule also anticipates a role for an ombudsman and a system for addressing beneficiary complaints and appeals. We support these provisions of the proposed rule.

Payment basis

Payment adjustment to account for inflation

CMS proposes that the competitively determined item prices be increased annually over the three year life of the contract by the CPI-U as are payment rates in the fee schedule. We suggest that you eliminate any automatic payment adjustment.

Establishing an automatic annual update makes it possible for prices to rise faster within the competitive bidding areas (CBAs) than in areas using the fee schedule in the event of a payment freeze or a payment reduction. If the prices rise within the CBAs, it is possible that they could overtake fee schedule prices and result in higher spending in CBAs than outside them. There are alternatives to automatic updates.

One alternative is bidding a single price for the term of the contract. This would require the bidders to estimate the rate at which their own costs will rise over the contract period and set their bid prices accordingly. This alternative could result in higher savings for the program if some bidders can not only offer lower prices in year one than their competition, but also lower cost growth over time. However, it is possible that removing the annual payment adjustment could result in higher bids in year one if bidders build in a substantial hedge against future cost increases.

As another alternative, CMS could allow each bidder to either specify an annual adjustment or propose bids for each item for each year of the contract. CMS would then use a discount rate to reduce all bids to a base year for comparison. This alternative would give suppliers the most freedom in designing their bids.

Authority to adjust payments in other areas

CMS asked for comments on how information from competitive bidding for DMEPOS should be incorporated into the fee schedule for areas outside of CBAs. We support using the price signals from competitive bidding to inform the fee schedule in all areas. For items whose bid prices converge across CBAs, CMS could change national or regional fee schedules fairly rapidly. For prices that do not converge, CMS should identify market characteristics that are related to price differences and use these analytical results to determine how rates for items in other areas should be adjusted.

Competitive bidding areas

MSAs for 2007

CMS asked for comments on the selection method for the ten MSAs in which the competition will occur in 2007. The method proposed in this rule would rank MSAs based on their total population, total DMEPOS charges, charges per beneficiary, and the number of DMEPOS

suppliers per DMEPOS users. These selection criteria are well suited to ranking and selecting MSAs in which competitive bidding is most likely to generate the most substantial savings and to offset the costs of implementing the competitive bidding program.

In addition to ranking MSAs on the total number of DMEPOS suppliers, we suggest that CMS also consider the numbers of suppliers of constituent categories of DMEPOS; for example, oxygen and supplies or hospital beds. If there are enough suppliers to support competition in each of the constituent markets within an MSA, then it should be included in the competitive bidding process. Otherwise, it should not be selected. Our research on this topic showed that the constituent markets can differ from the total DMEPOS market.

Establishing the competitive bidding areas for 2007 and 2009
The proposed rule contemplates setting competitive bidding areas as equal to MSAs, larger than MSAs, or smaller than MSAs. At least for the first round of competition, we suggest that CMS define CBAs to be equal to MSA boundaries. MSAs are well defined and known to bidders. For simplicity and transparency, those definitions should be used without alteration. In addition, because CMS is choosing bidding areas based on MSA characteristics, this would seem to be the relevant area. In future rounds of competition, a larger area could be considered if those areas equate better with markets and are used to define and choose competitive areas.

Submission of bids under the competitive bidding program
Physicians
CMS needs to clarify how physicians will provide DME in CBAs. The self-referral law that prohibits physicians from supplying most DME items seems to conflict with the proposed rule's requirement that all bidders must bid on all items within a category of DME. It appears that physicians cannot be bidders.

We suggest that CMS allow physicians in CBAs to continue to supply the limited range of items currently allowed under law and not require them to bid. However, physicians in CBAs should be reimbursed at the competitively determined prices. Prohibiting physicians from supplying DME to their own patients might substantially inconvenience beneficiaries—for example, not being able to provide crutches to a beneficiary whose leg has just been placed in a cast.

Conditions for awarding contracts
Assurance of savings
CMS solicited comments on the various methods for assuring savings under the competitive bidding program. In the proposed rule, two different methods are proposed: One method would reject any bid that includes any item priced above the current fee schedule price. The other method is indifferent to the prices of individual items so long as the amount to be paid

under the bid for the entire category is less than it would have been if each item in the category were priced at the current fee schedule. The proposed rule favors the former interpretation.

We would propose that the program should accept bids that include some items with prices above the current fee schedule so long as the total bid would result in lower spending than the current fee schedule. Allowing this variation is likely to give CMS the most accurate price signals for both over- and under-priced items. Improving accuracy can remove incentives to over- or under-provide products or services depending upon the relative profitability of the products and ameliorate access problems that beneficiaries may have if they seek less profitable products. Also, in the specific case of competitive bidding, if the bidders are not permitted to bid a higher price for items that cost them more to supply than the current fee schedule allows, then they will not offer the program substantial discounts on the items that are currently priced too high.

We note that in the competitive bidding demonstrations, the program achieved substantial savings even though several of the items in each of the categories were priced through the bidding process above the fee schedule amount.

Determining single payment amounts for individual items

Rebate program

CMS solicited comments on the proposed rebate program. Although the goal of sharing potential provider profit with the beneficiaries is laudable, it is preferable to obtain the best price through competition not through a rebate. Adding a rebate program would not be advisable. A rebate program will complicate the design and administration of the program and possibly induce additional demand for DME, as well as raise the risk of fraud and abuse as noted in the proposed rule. The proposed rule would prohibit advertising of rebates, yet at the same time require a supplier provide rebates for all beneficiaries if any beneficiary received one. Enforcing either of these provisions would complicate administration of the program. If a beneficiaries' cost sharing were reduced or eliminated, demand for DME may be induced (allowing a beneficiary to be paid to purchase DME if the rebate exceeded cost sharing would be even worse). Demand could also be channeled to more expensive substitute items if rebates made those items less expensive for the beneficiary. Induced demand and item substitution could increase rather than decrease Medicare spending. Beneficiaries will already get the benefit of reduced cost sharing as rates go down. Competition should also reduce the opportunity for rebates over time.

Fee schedule for home dialysis supplies and equipment

CMS proposes to establish a fee schedule for home dialysis supplies and equipment furnished by DME suppliers (also referred to as the method II payment option). Currently, CMS pays suppliers for home dialysis supplies and equipment on a reasonable charge basis that

cannot exceed the national median payment (composite rate) that CMS would have paid to hospital-based facilities. (CMS calls the composite rate paid to dialysis facilities the method I payment option.) The agency proposes to derive the fee schedule from charge data for allowed services furnished by suppliers in 2005 and to maintain the cap under which monthly payments to suppliers cannot exceed the composite rate for hospital-based facilities. CMS's proposal continues to pay suppliers up to 30 percent more than dialysis facilities for furnishing one form of home dialysis—continuous cycling peritoneal dialysis (CCPD).

We are concerned that the payment rate for CCPD paid to DME suppliers does not reflect efficient suppliers' costs. There is no evidence to suggest that suppliers incur higher costs to furnish CCPD than dialysis facilities incur. The Office of Inspector General (OIG) (2003) reported that Medicare paid $15.3 million more and beneficiaries paid an additional $3.1 million to DME suppliers compared with payments to dialysis facilities for CCPD in 2000.

CMS should consider revising the payment provisions so that payment does not vary between DME suppliers and dialysis facilities. The OIG recommended that CMS limit suppliers' payment rate for CCPD items to equal the rate paid to dialysis facilities. Doing so would decrease spending for beneficiaries and the Medicare program. Paying the same rate for the same services across different settings would lessen CMS's administrative burden.

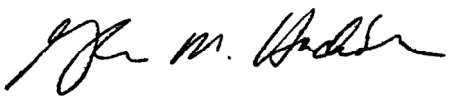
The Commission is considering ways to improve payment for home dialysis. Competitive bidding may be one potential way to encourage efficiency. In future work, we plan to consider ways for Medicare to modernize payment for home dialysis services.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman