

Response to the Congressional Hearing on Medicare's Durable Medical Equipment Competitive Bidding Program

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Summary

On 11 September 2012, the Subcommittee on Healthcare and Technology of the United States House Committee on Small Business led by Chairwoman Renee Ellmers (R-NC) and Ranking Member Cedric Richmond (D-LA) held a hearing on Medicare's Durable Medical Equipment Competitive Bidding Program, which is in its pilot stage, but soon is to expand to over one-half of the country. The program is administered by the Centers for Medicare and Medicaid Services (CMS). Under the 2003 Medicare Modernization Act, Congress mandated CMS to identify providers and price home medical equipment through competitive bid. The hearing included four witnesses:

- Lawrence Wilson, Director of the Chronic Care Group with CMS, testified on behalf of CMS; he is one of the CMS staff that runs the Medicare Competitive Bidding Program. He described the DME Competitive Bidding Program as "successful."
- Peter Cramton, Professor of Economics, University of Maryland, testified as an auction expert, who has designed and implemented auctions in many industries and countries over the last twenty years. He argued that Congress must insist that CMS replace its fatally flawed auction program with an efficient auction based on best-practice and science and thereby achieve least-cost sustainable supply of quality home medical equipment for beneficiaries.
- Tammy Zelenko, President and CEO of Advacare Home Services, testified as one among the thousands of the small businesses that have participated in the Medicare auction. She described the serious problems of the program for any business, stating, "let us be clear: This bidding program is anti-small business. It is a business and job killer."
- Randy Mire, owner of Gem Drugs, explained the important role of independent community pharmacies in the delivery of Medicare-funded health services and goods to beneficiaries.

The hearing helped illuminate the serious problems with the current program. As an auction expert and someone quite knowledgeable with both CMS' current program and the stakeholders' Market Pricing Program, which replaces the current program with a modern efficient auction, I provide comments on CMS' testimony.

I identify two points of agreement with CMS:

1. *CMS' Competitive Bidding Program is not an auction.* This is a harsh critique given the 2003 Congressional mandate that requires that CMS identify providers and price services with an auction (competitive bid). To me as an auction expert (and not a lawyer), CMS' program is in violation of the law.

2. *CMS' Competitive Bidding Program has such poor bidding incentives that a provider's rejection of a supply contract is unrelated to its bid.* In contrast, in an efficient auction, the provider is motivated to bid its cost, and therefore the decision to reject a contract is entirely determined by its bid: reject the contract if and only if the contract price is below the bid (the bidder's cost).

I also identify several points of disagreement with CMS and explain why CMS is wrong:

1. *CMS claims it has worked closely with stakeholders to design and implement the program.* It has not. It has dictated the terms. For otherwise it would not be possible to come up with a program that all stakeholders agree is badly flawed. CMS stands alone in supporting this program.
2. *CMS claims to be open to improvements as the program expands.* Then why for two years has CMS made no reform of the program in light of the unanimous agreement among experts and other stakeholders on the flaws of the program. Certainly CMS should explain why the stakeholders are wrong. CMS to date has not questioned the validity of the stakeholders' critique.
3. *CMS claims the program encourages small business participation.* In fact, the program—even when implemented in less than 9 percent of the country—has led to the elimination of about 4,000 companies as contract suppliers, about 90% of the total.
4. *CMS claims that the dramatic drop in utilization post-competitive bidding was the result of rampant overutilization, which the program has corrected.* Instead, the drop in utilization is a result of access problems—the beneficiaries are unable to get the supplies they need from the Medicare program and so are getting their supplies outside the program.

In response to critique of its Competitive Bidding Program, CMS has countered with two assertions: (1) the program is saving Medicare and beneficiaries a lot of money, and (2) there are no adverse health outcomes as a result of the program. Neither assertion is supported by fact.

To see this consider the following thought exercise: Suppose CMS decided to set the price of two auctioned products—oxygen and mail-order diabetes test strips—to \$0. This is easily accomplished by CMS setting the floor and ceiling for these two products to \$0. Then all bids received would be zero and the median price would be zero. What would happen? Clearly even those who accept the price of zero and become contract suppliers will refuse to supply these products at such a price. Thus, utilization falls to zero together with the price. The result is a huge apparent “cost savings” for Medicare, when in fact what is observed is a denial of access. The apparent cost savings for beneficiaries is also a mirage. The beneficiary whether a diabetic, an oxygen patient, or both, still gets her home medical supplies; she simply gets the supplies outside the Medicare Competitive Bidding Program and pays substantially more as a result. What happens with diabetes is especially interesting. Not even Medicare saves money, since the beneficiary unable to get her test strips via mail order instead goes to the retail pharmacy, where both Medicare and the beneficiary pay about 260% more.

In the Round One Rebid, CMS wisely chose to set the price above zero so as to induce a majority of suppliers to sign the supply contract. But the impact of CMS' program is the same as in the thought exercise above: false cost savings and denial of access. The Medicare auction requires significant reform.

Two points of agreement

CMS: “This is not an auction”

[Mr. Wilson](#).¹ “This [the CMS Competitive Bidding Program] is not a procurement, a government procurement, it is not an auction.”

In response to Mr. Wilson’s statement that the CMS Competitive Bidding Program was not an auction I testified:

[Mr. Cramton](#). “In the words of Mr. Wilson, he said, quote, ‘This is not an auction.’ This is one thing I completely agree with Mr. Wilson about, it is not an auction, and that is a very damning critique for the following reason: In 2003, Congress passed legislation that required that CMS conduct a competitive bidding program for durable medical equipment. Competitive bids and auction are the exact same thing. So he is saying that CMS is not abiding by the law, and I would agree with him on that point. It is one of the few things I agreed with him on: it is an arbitrary pricing process...only worse since it excludes over 90% of the market (rather than any willing supplier).”

CMS’ slow progress with auctions is one clear indicator that its problems are not limited to auction design but also auction implementation. It is remarkable that Congress passed a law in 2003, the Medicare Modernization Act, mandating auctions for home medical equipment, and CMS did not manage to implement a “Round 1” pilot program—covering less than 9 percent of the country—until January 2011. Congress should not tolerate such negligence.

Given this history it is not surprising that Mr. Wilson said, “This [Market Pricing] program would seem to require about 8 years to implement.” There is no need for the auction implementation to take so long. One year is a better estimate of what would be required provided Congress specifies an aggressive timeline so that the implementation is done on a fast track and with the aid of experts.

CMS: “The winners rejected supply contracts not based on their bids” Implication: Bids are not related to costs

[Mr. Wilson](#). “[W]hen you looked at their bids they didn't not accept because their bid was higher than the price or lower than the price, it sort of cut both ways. So it was obviously for some other business associated reason.”

There is only one reason to reject a supply contract: the provider cannot supply the product category without loss; that is, the CMS price is below the provider’s cost.

[Mr. Cramton](#). “The current system does not elicit the true costs from the providers. Mr. Wilson stated that in his response, and I quote, “The winners rejected or accepted not based on their bid.” That is, the consideration was just what Ms. Zelenko said. The consideration in accepting or rejecting was whether she thought she could provide the goods and services at the price. Okay? So it has nothing to do with her bid. And in a competitive, efficient auction, the trick of making an efficient auction is to elicit the

¹ Speaker hyperlinks are to the exact point in the hearing video where the statement was made. In this way the reader can confirm the quote and establish context and tone.

bidder's true costs, and then, in fact, the acceptance or rejection would be based upon the bid. And that is exactly what an efficient auction does when it identifies the clearing price. Those that bid below the clearing price are accepted; those that bid above are rejected.”

This issue also illustrates the lack of transparency in the CMS auction. If the experts had the bidding data (perhaps with the bidders’ names removed to preserve confidentiality of the bids), then we could easily see whether a bidder’s rejection of a supply contract was related to its bid, as Mr. Wilson says. Assuming he is right then the pilot supports the fact that there are serious problems with the bidding incentives in the CMS auction, as demonstrated in theory and the experimental lab, and seen in the field with the need to a floor and ceiling on bids. It is telling that Mr. Wilson does not even realize that his empirical observation indicates a serious problem with the auction.

Four points of disagreement

CMS: “CMS worked closely with stakeholders to design and implement the program.”

Mr. Wilson. “CMS worked closely with stakeholders to design and implement the program in a way that is fair for suppliers and sensitive to the needs of beneficiaries.”

Despite this supposed collaboration with stakeholders, CMS managed to come up with a design that stakeholders—beneficiaries, providers, non-CMS government leaders, and auction experts—all agree is flawed.

Mr. Cramton. “So there is unanimous consent on this, and, in fact, I have been working on this for 2 years. I have talked to people around the world, and, indeed, I have never heard anybody disagree with the remarks that I presented today and that are presented in my [written testimony](#) before you.”

CMS: “We are open to improvements as the program expands.”

Mr. Wilson. “We continue to be open to further improvements as the program expands.”

Really?

- Then why in the face of overwhelming practical scientific evidence of severe problems, does CMS make no significant changes to the program as the program expands to one-half of the country. The most serious flaws, non-binding bids and the median pricing rule were identified by 167 auction experts in September 2010 and sent to CMS not only by the experts but by numerous Congressman.
- Why does CMS not release any of the essential data necessary to properly evaluate the pilot program? Remarkably the absence of data even extends to the DMEPOS Competitive Bidding Program Advisory and Oversight Committee (PAOC) established by Congress to monitor the program. For example, listen to Barbara Rogers, Medicare beneficiary, PAOC Member, and President/CEO of the National Emphysema/COPD Association, who spoke at an update to Congress on the Competitive Bidding Program, “Well, I will tell you, when I go to bed at night and I turn my life over to my ventilator—I get emotional here—when I do that, it's not a widget to me. You know, it is my life. And people's life and death are affected by this program. And it's my experience that

CMS has no concept, or else they don't care. When I ask CMS as a PAOC member for information or suggestions, 90 percent of the time I'm given two answers. It's a legislative issue, we don't deal with it; or it's confidential and we can't tell you. So to me, who are they accountable to? You know, they don't seem to be accountable to anybody.”²

- Why does CMS not commission an independent assessment of its pilot so that there is some possibility they might be able to improve it? A basic tenant of science is peer review. There is a good reason for this. Only through peer review can one have any faith in assertions, especially coming from those with a conflict of interest.³ The designer and implementer of a program cannot be relied on to provide an objective critique of its own program. This is common sense.

Mr. Cramton. “If one takes a look at the 1-year report that CMS did, which I think was released on April 17th of 2012—it is on my Website, it is on their Website—you will see a [16-page report](#) that does not address any of the issues that all of the experts agree are extremely serious problems with their program. Not one word about any of the issues. So it is not a critique, it doesn't give data, it just makes an assertion.”

- Why does Mr. Wilson immediately leave the hearing before the other testifiers have spoken? This does not seem like appropriate behavior for someone directing a program of an agency that is “open to further improvements as the program expands.” Such an act is especially offensive in light of Mr. Wilson’s lack of understanding of basic elements of the Market Pricing Program.

Mr. Wilson. “We talked about choice a little bit today. This assigns patients essentially to certain small suppliers, it has a small supplier target that says they get 30 percent of the business. The only way to implement that is to assign a patient to a supplier and take away their choice. That is a concern for me. So I think there is some issues and concern there that need to be addressed, but I don't see replacing a system that is working for one that has some problems.”

- In fact, if Mr. Wilson had any understanding of the Market Pricing Program, an early draft of which was available in January 2011, he would know that a key tenant of MPP is beneficiary choice, which is supported in a variety of ways, the most important being that the beneficiary gets to select among any auction winner in the 20% of cases that are currently under auction contract and can select among any qualified supplier in the remaining 80% of the cases. The hundreds of stakeholders that developed MPP are well aware of the benefits of beneficiary choice and take it seriously—in sharp contrast to CMS’ Competitive Bidding Program. These features have been part of the Market Pricing Program, since January 2011 and were in fact part of the proposal initially presented to Mr. Wilson on 1 November 2010.

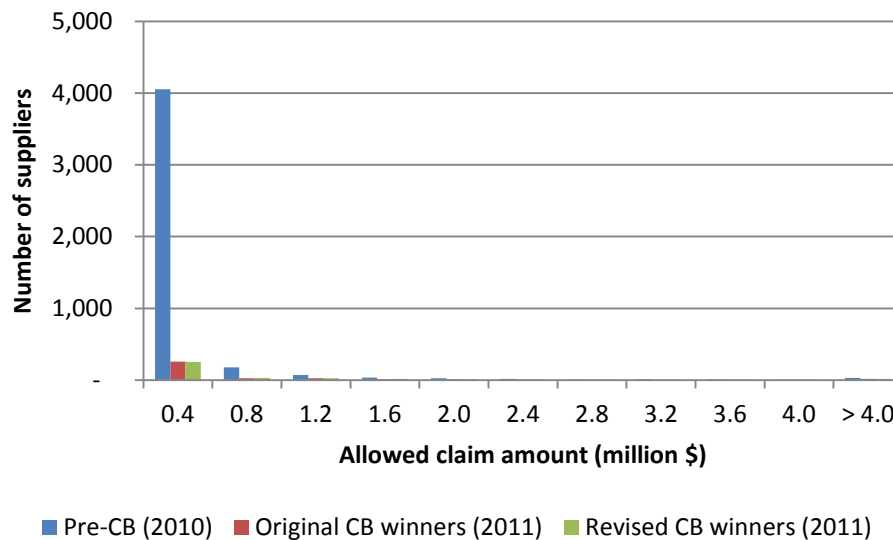
² [Competitive Bidding Congressional Update—What You Need to Know](#), Longworth House Office Building, sponsored by U.S. Representative Sue Myrick (R-NC), 24 May 2011. [[Video of panelists](#), [Transcript of entire event](#)]

³ For more on conflict of interest see my written testimony at p. 17.

CMS: “The Competitive Bidding Program encourages small business participation”

[Mr. Wilson](#). “Most importantly, the regulation established a special 30 percent target for small supplier participation in the program. CMS was very pleased that we exceeded this 30 percent target in the nine Round One areas with 51 percent of contracts going to small suppliers.”

The reality is that the CMS Round One Rebid was a disaster for small businesses. Even when applied to less than 9 percent of the US population, CMS’ Competitive Bidding Program excluded many thousands of small business providers. The facts are shown in the chart below (page 12 of my [written testimony](#)):



Yes, 51 percent of the remaining providers (CB winners) are small businesses, but this is little consolation to the 90 percent who were eliminated by an auction process that auction experts describe as “bizarre” in the *New York Times*.⁴ The painful reality is that 51 percent of nearly zero is nearly zero.

CMS: “There was rampant overutilization under administrative pricing”

[Mr. Wilson](#). “[T]here was rampant overutilization under the prior system [administrative pricing].”

This bold claim is central to CMS’ argument. There is no denying that utilization has dropped dramatically in the nine competitive bidding areas.⁵ There are two possible sources for the drop in utilization:

⁴ Ayres, Ian and Peter Cramton, “[Fix Medicare’s Bizarre Auction Program](#)” (with Ian Ayres), Opinion Pages, *New York Times*, 30 September 2010.

⁵ See for example AMEPA (2012), “[Reductions in Allowed Claims Prove Limited Patient Access.](#)” and Cramton, Peter (2012) “[The Hidden Costs of a Flawed Medicare Auction.](#)” University of Maryland, January 2012. [Data] The “Hidden Costs” study was based on a FOIA request to CMS. Analysis of the data is limited as a result of the significant lag between the time CMS receives a claim and the time it is recorded as an allowed claim. To address this limitation I sent a follow-up data request, requesting the same data fields but updated to better reflect the full set of allowed claims in 2011. The data request was completed by PDAC and underwent two months of quality control checks. At this point PDAC normally sends the data directly to me, however, CMS apparently requested that the data be sent to them instead. CMS received the data on 17 August 2012. One month has gone by and I still

1. a decline in fraudulent claims—what CMS refers to as overutilization, or
2. a decline in access—those with legitimate claims getting home medical equipment outside of the CMS Competitive Bidding Program.

CMS has attempted to back up its overutilization claim in its [one-year update](#). This critical issue is addressed in a single paragraph of the CMS one-year update at page 5: “CMS’s monitoring revealed declines in the use of mail-order diabetes test strips and continuous positive airway pressure (CPAP) supplies in the competitive bidding areas. In response to these declines, CMS initiated three rounds of calls to users of these supplies in the nine competitive areas, two rounds of calls for users of mail-order diabetes test strips and one round of calls to users of CPAP supplies. In each round, CMS staff randomly identified 100 beneficiaries who used the items before the program began but had no claims for the items in 2011. The calls revealed that in virtually every case, the beneficiary reported having more than enough supplies on hand, often multiple months’ worth, and therefore did not need to obtain additional supplies when the program began. This would suggest that beneficiaries received excessive replacement supplies before they became medically necessary. CMS concludes that the competitive bidding program may have curbed inappropriate distribution of these supplies that was occurring prior to implementation.”

CMS provides no further details of the survey, such as when was the survey conducted, what questions were asked, or what were the responses to questions. We somehow are to believe that the drawing down of beneficiary inventories is simply the result of “curbed inappropriate distribution of supplies.” This argument is illogical. The behavioral response of access difficulties is first to run down inventories—it is not surprising that beneficiaries keep some inventory on hand of supplies necessary for their survival—and second to purchase the needed supplies outside of the Medicare program. If an oxygen patient cannot get her oxygen within Medicare post-competitive bidding, then she will get it outside of Medicare. The alternative in many cases would be to perish. Thus, the CMS survey is entirely consistent with access problems in both diabetes and oxygen, two of the largest products under competitive bidding. Even if we assume as CMS asserts that beneficiaries are simply running down massive inventories, then the “cost savings” as calculated by CMS is clearly a mirage, since utilization should spring right back to historic levels once the inventories are exhausted.

Postscript

Immediately following the Medicare auction hearing, I left for Washington Dulles Airport to fly to London, where I spent the rest of the week advising the United Kingdom’s Department of Energy and Climate Change on the design of the UK electricity market and the Office of Communications on the UK’s upcoming 4G spectrum auction for mobile communications.

The contrast with my CMS experience over the last two-years was so dramatic that I thought I had been transported to an alternate universe where truth was truth and rational thought was not only valued

have received nothing. This is one more example of the complete lack of transparency of the program. There is no reason why basic information like what I asked for is not immediately made available to the public. Congress should insist on a much higher level of transparency. The saga of my effort to get basic data from CMS is documented in [Follow-up FOIA Data Request](#).

but essential to government decision making. My three days in London were filled with tireless informed debate of the difficult issues of designing auctions in complex economic settings—electricity and telecommunications. As discussed in my testimony, I am well aware that the US government also is capable of such innovative expert decision making—my testimony gave the FCC’s spectrum auctions and FERC’s electricity markets as clear examples.

One thing I do know: Congress and the White House must act to reform the Medicare auction. If we do not effectively apply market methods to health care, Medicare is unsustainable.