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ISSUE BRIEF

Reforming CMS' Competitive Bidding Process to Improve Quality and Sustainability: An Update

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Summary

The Centers for Medicare and Medicaid Services (CMS) has struggled for decades to design a sensible reimbursement system for durable medical equipment – known in the federal government as durable medical equipment, prosthetics, orthotics and supplies, or DMEPOS. These crucial medical supplies are prescribed by healthcare providers for patients to use in their homes and include wheelchairs, oxygen equipment, walkers, and CPAP machines.

Starting back in 1989, CMS used a fixed fee system to compensate suppliers. This payment system was widely regarded as a failure because the prices for DMEPOS became disconnected from the supplies' actual costs and value. Critics included the U.S. Government Accountability Office (GAO), the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG), the Medicare Payment Advisory Commission (MPAC), and even members of Congress.

The reforms adopted in 2011 were supposed to address these flaws. Rather than rely on a fixed fee schedule, CMS initiated a competitive bidding system that could have made sense had the 2011 reforms adhered to the tenets of a sound bidding process. But the reforms did not.

Specifically, the 2011 competitive bidding process set the compensation for all selected bidders based on the median of all winning bids. Suppliers also have no obligation to supply the designated equipment and supplies under the contract because they have the option to opt out of their contract should they be selected, even after the agency added the bond forfeiture requirements. Among the adverse consequences, these features all but ensured that the ensuring supply shortages would occur.

Due to these flaws, the federal government is reforming the payment system once again. Unfortunately, these reforms are also destined to fail because the reformed competitive bidding system still does not adhere to the core tenets of an efficient system. In this case, rather than compensating suppliers with the median winning bid, the proposed new system will use the bid at the 75th percentile. It also continues to allow bidders to walk away and not fulfill their contract. Moreover, it proposes setting the bid ceiling such that bids cannot fluctuate up or down with the market; they will only be driven down. The problems of uneconomical pricing and supply shortages will persist as a result.

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A more efficient bidding process would set the price that CMS offers suppliers equal to (or nearly equal to) the bid that was high enough to ensure that there will be adequate supplies, but no higher. Further, the bidding structure should encourage bidders to fulfill their promised supplies by requiring a surety bond, mandating specific performance obligations, and reimbursing winning bidders at rates that match their bids. As a final criterion, the latest reforms should have eliminated the opportunity for bidders to game the auction – a problem that plagues the current median-based compensation system.

Failing to meet these criteria, the resulting prices for DMEPOS will still be disconnected from the actual value created by these needed medical supplies and the threat of continued supply shortages will persist.

The Competitive Bidding Program Established in 2011 Was Structurally Flawed

We documented the flaws of the 2011 competitive bidding process in a July 2018 analysis.[1] As we noted in 2018, "an efficient competitive bidding process should encourage bidders to reveal their cost structures, discourage cheating, adequately fulfill the required demand, and minimize the prices that Medicare pays for durable medical equipment."[2] This system generated budgetary savings, but these proved temporary, and failed to meet the other typical efficiency criteria. The structure was destined to be inefficient because the bidding process:

- compensated all winning bidders based on the median value of the winning bids
- allowed winning bidders to opt out of their commitments, and
- relied on an opaque composite bid structure.

Using the median value of the accepted bids to compensate all winning bidders is highly unusual to say the least. Cramton et al. called it "a never before seen" auction.[3] Rather than this atypical auction, the government generally uses first-price sealed bid or uniform-price auctions, which compensate winners based on the bids they submitted.

While not without flaws, the outcomes from these typical bidding structures are consistent with those from an efficient competitive bidding process. Since there are multiple suppliers competing against one another, these bidding models incentivize bidders to keep their prices affordable. Otherwise, the firms that price too aggressively will risk losing the business opportunity.

Being aware of their own finances, firms will also ensure that their bid is sufficient to cover their specific production costs. The push-and-pull of these incentives helps to ensure that the prices paid in a typical bidding process reflect suppliers' actual cost structures – a key efficiency criterion of a competitive bidding process.

When combined with the typical requirement that, by bidding, the participants agree to fulfill the terms of their bid should they be selected, these structures ensure that there will be adequate supplies of the necessary products and services as well – another key efficiency criterion. The transparency of the bidding process also helps minimize any cheating and ensures that prices are not overly inflated.

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The median bid structure does not create these positive incentives. The rationale for a median bid structure is to account for the potential that there are some high-cost marginal bidders – the firm whose marginal contribution ensure there will be adequate supplies – that will drive up total costs under a single-price auction.

However, by definition of being *the median*, the payment offered to the winning firms will be below the actual bid offered by 50 percent of the DMEPOS suppliers. Consequently, half of the winning bidders are at risk of losing money should they commit to fulfilling their contract.

Perhaps because half of all bidders are at risk of losing money, the previous structure also allowed winning bidders to opt out of their commitments with minimal cost. Since durable medical equipment suppliers are

not in business to lose money, all winning bidders whose costs exceed the government's offered price will rationally opt out and decline to fulfill the terms of the contract rather than sell the equipment at a loss to the government. Unsurprisingly, this structure has led to significant supply shortages.

Making the problem worse is the fact that the bidding structure incentivizes bidders to game the system. For instance, compensating all winning bidders with the median bid allows each firm to influence the revenues that their competitors receive. This type of impact incentivizes counterproductive bidding behavior.

This structure also increases firms' chances of being selected as a supplier by submitting a lowball bid for the product category. The risks of a financial loss are minimized because the actual compensation is based on the median bid not the firm's actual lowball bid. Further, if the ultimate prices offered are inadequate, the supplier always has the option to opt-out, enabling bidders to game their pricing strategy without risking any financial losses.

The median bid structure also biases the equipment toward lower cost, and inherently lower quality, medical equipment. To simplify, imagine there are two types of supplies – a high-cost higher quality product and a low-cost lower quality product. A firm will enhance its chance of being selected by offering to supply the equipment at a lower price. Basing its bid on the high-cost equipment will decrease the firm's chances of being selected while basing its bid on the low-cost product will increase its chances. Bidders are consequently incentivized to provide low-cost equipment.

And this is what has been happening. As we warned in our 2018 analysis, patients are experiencing "adverse consequences" including "reduced product quality, declining health outcomes, and eroding sustainability of the market."

The New Bidding Structure Is Still Fundamentally Flawed

Since the paper was published in July 2018, CMS rightly noted that significant flaws plagued the previous rounds of DMEPOS bidding and, beginning in 2019, paused future rounds. In response to these problems, CMS is now proposing a new competitive bidding program.[4] Unfortunately, the new bidding structure would, if implemented, still be flawed. It would lead to similar quality and shortage problems that arose under the previous competitive bidding program.

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To start, the proposed compensation for winning bids would still be inefficient. Rather than using the median bid, the new bidding structure would use the 75th percentile bid – the bid where 25 percent of the winning bidders will offer a price that will end up being higher than the reimbursement price CMS will pay and 75 percent will offer a price that will be lower.

The recommendation that the compensation for the winning bidders should be raised from the median winning bid to the winning bid at the 75th percentile demonstrates that CMS recognizes the flaws in the median bidding structure. However, using the 75th percentile compensation level would still create the same problems as the median value system – just slightly less.

In this case, the 75th percentile methodology would ensure that 25 percent of the winning bidders will have to provide supplies at prices that are below the amount they bid. Thus, the same risk exists – the prices CMS offers would be below their costs and are, from the perspective of these higher-cost firms, uneconomical.

Because the payment rate that CMS would offer winning firms will be uneconomical for a substantial share of the selected suppliers, it probably makes sense that CMS is continuing to allow bids to be nonbinding. Without these assurances, many firms would likely not participate at all. Yet, the reality that bids are still nonbinding means that the problems of strategic pricing will persist.

Since the new proposed system still will price the DMEPOS below the bid for a significant share of the winning bidders (in this case 25 percent), a large share of the winning bidders would also be likely to opt out of their commitments. While better than 50 percent of the market at-risk, this sizable share is still problematic. The problem of supply shortages that plagued the previous competitive bidding system will likely persist as a result.

It is also important to recognize that 25 percent of the bidders does not necessarily imply that 25 percent of the supplies are impacted. The proposed methodology would weigh all bids equally regardless of how much capacity each bidder is offering. Thus, a greater share of the total medical supplies could be at risk should the bidders with the top 25 percent of costs represent more than 25 percent of the volume.

> **“The pressure created by the bid ceiling will worsen the shortage problem for patients requiring necessary medical equipment.**

The shortage problem that plagued the previous bidding process could be potentially worse under this new system. CMS has proposed to use the payment amount from 2019, “adjusted by an inflation factor, plus 10 percent” as a bid ceiling.[5] Thus, there is a binding price control constraining the new bidding process.

Price controls – whether on rents or medical supplies – inevitably cause shortages when, as is likely in this case, they are set below the market clearing price. The pressure created by the bid ceiling will worsen the shortage problem for patients requiring necessary medical equipment. Additionally, the structure of the new bidding system would still encourage strategic bidding that obstructs an efficient bidding process and biases the supplies toward lower quality lower cost equipment.

Considering all process inefficiencies, it is likely that the changed bidding structure will not adequately resolve the problems inherent in the previous process. Shortages of medical supplies and strategic bidding activities that distort prices are the expected outcomes, consequently.

Taking a Holistic Perspective is Essential for Generating Medicare Savings

The continued shortage problem is also troubling for its broader implications. Typically, the success of the DMEPOS reimbursement system is judged against the savings it creates on medical equipment. And reducing the costs of medical equipment is undoubtedly important. However, confining the cost impacts to just the durable medical equipment savings provides an incomplete view.

Ultimately, the goal is to improve patient outcomes while generating systemic savings for the Medicare program. A savings approach that is *penny-wise but pound-foolish* fails to achieve this goal. Being penny-wise and pound-foolish accurately describes the previous competitive bidding process.

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Even though this structure was initially realizing savings, it also incentivized the use of lower cost medical supplies. Lower quality medical equipment risks the savings that home healthcare is supposed to deliver and denies patients of the oft-preferred home-based delivery of care.

For instance, a U-Penn study of Medicare hospitalizations found that "home health care was associated with an average savings of $4,514 in total Medicare payments in the 60 days after the first hospital admission."[6] Importantly, despite a "5.6 percent higher 30-day readmission rate than similar patients discharged to a skilled nursing facility (SNF)…there was no difference in mortality or functional outcomes between the two groups." Since home healthcare typically requires durable medical equipment, having the right supplies tailored to patients specific needs is essential.

These results highlight the potential higher systemic costs that occur when patients receive lower quality or ill-suited home-based durable medical equipment. They also demonstrate that, rather than only considering the cost savings on medical equipment in a vacuum, CMS should take a holistic perspective that considers total Medicare expenditures when evaluating the bidding process for DMEPOS.

Conclusion and Recommendations

There is broad agreement that CMS' initial competitive bidding process was unable to fulfill its intended goals. Yet, the suggested replacement has failed to adequately address these problems. Consequently, the problems of shortages, lower-quality medical supplies, and an inefficient competitive bidding process will likely persist.

Rather than implementing these atypical and inefficient bidding structures, CMS should implement a single-price bidding structure. This is the typical bidding system the government uses to purchase supplies and will compensate suppliers based on the bid that is just high enough to ensure there are sufficient supplies available – pay bidders what they bid.

To account for the excessive costs that could arise in those instances where the marginal suppliers in certain markets are excessively high, the compensation should include an appropriate discount, with the size of

the discount being tied to the excessiveness of the marginal supplier's costs. One way to accomplish this goal would be to establish the clearing price using the supplier's actual ability to supply and setting the demand point at an amount slightly less than 100 percent to ensure competition.

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To enhance this structure, CMS should hold bidders accountable for their bids including the intended use of a surety bond. Ideally, CMS would not include any bid ceiling either, but if one is included the ceiling should be flexible downward as well as upward to minimize its damage. In combination, these changes would ensure adequate supplies and encourage bids that accurately reflect the costs of providing the DMEPOS.

As we concluded in our 2018 analysis, it is also important to ensure that "the bidding areas are appropriately drawn." Poorly delineated bidding areas where the costs of providing care vary will cause either higher costs in the low-cost region or exacerbate the equipment shortage problems. These adverse consequences can be avoided by ensuring that the costs of serving the area are similar throughout.

Ultimately, competitively bidding the contracts for DMEPOS is the right reform for providing the more standardized medical equipment that patients require for their home healthcare needs. The key is to get that structure right.

Endnotes

1 Winegarden W "Reforming CMS' Competitive Bidding Process to Improve Quality and Sustainability" Pacific Research Institute, July 2018.

2 Ibid.

3 Cramton P, Ellermeyer S, and Katzman B (2015) "Designed to Fail: The Medicare Auction for Durable Medical Equipment" *Economic Inquiry,* Vol. 53, No. 1; January.

4 "Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HHPPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies" A Proposed Rule by the Centers for Medicare & Medicaid Services July 2, 2025, https://www.federalregister.gov/documents/2025/07/02/2025-12347/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate.

5 Ibid.

6 Werner RM, Coe NB, Qi M, and Konetzka RT "Patient Outcomes After Hospital Discharge to Home with Home Health Care vs to a Skilled Nursing Facility: Home health care leads to savings despite increasing hospital readmissions" *Penn LDI*, March 8, 2019, https://ldi.upenn.edu/our-work/research-updates/patient-outcomes-after-hospital-discharge-to-home-with-home-health-care-vs-to-a-skilled-nursing-facility/.

About the Author

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Wayne H. Winegarden, Ph.D. is a Senior Fellow in Business and Economics at the Pacific Research Institute and director of PRI's Center for Medical Economics and Innovation. He is also the Principal of Capitol Economic Advisors.

Dr. Winegarden has 25 years of business, economic, and policy experience with an expertise in applying quantitative and macroeconomic analyses to create greater insights on corporate strategy, public policy, and strategic planning. He advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, state legislative leaders, political candidates and trade associations.

Dr. Winegarden's columns have been published in the *Wall Street Journal, Chicago Tribune, Investor's Business Daily,* Forbes.com, and Townhall.com. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his Ph.D. in Economics from George Mason University.

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