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Before the Subcommittee on Health

House Committee on Energy and Commerce

On

**Medicare's Competitive Bidding Program for Durable Medical Equipment: Implications
for Quality, Cost and Access**

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I would like to thank Chairman Pallone, Ranking Member Shimkus, and members of the Energy and Commerce Subcommittee on Health for the opportunity to provide testimony for the hearing on "Medicare's Competitive Bidding Program for Durable Medical Equipment: Implications for Quality, Cost and Access."

My name is Karen Lerner and I am a Registered Nurse, Wound Care, Support Surface & Rehab Specialist for Allcare Medical in Sayreville, New Jersey. Allcare Medical is a full service HME company specializing in complex rehab equipment, clinical respiratory, wound care and support surfaces, as well as custom orthotics and prosthetics. Allcare Medical employs over 200 associates with three locations throughout New Jersey and one location in Pennsylvania and provides equipment and services to over 25,000 patients annually.

Allcare Medical is a proud member of the Jersey Association of Medical Equipment Services (JAMES) and the American Association for Homecare (AAHomecare). JAMES represents providers of home medical equipment in New Jersey. It is the goal of JAMES to keep its members informed of industry changes and related information necessary to maintain quality of care in providing home medical equipment, supplies and services to the patients.

AAHomecare is the national trade association for health care providers, equipment manufacturers, and other organizations in the homecare community. AAHomecare members serve the medical needs of Americans who require oxygen equipment and therapy, mobility assistive technologies, medical supplies, inhalation drug therapy, home infusion, and other home medical products, services, and supplies in the home.

I've been a Registered Nurse (RN) for the last 28 years, 14 years of which I worked with home medical equipment (HME). Unfortunately, I and many other providers have seen the significant flaws in the Centers for Medicare & Medicaid Services' (CMS) design of the bid program that will cause Medicare's most vulnerable beneficiaries to experience a range of unintended consequences that affect choice, access, and quality in the DMEPOS benefit. I am concerned that the HME competitive bidding program will result in beneficiaries experiencing more medical complications, increased use of emergency room care, and delays in hospital discharges

(increasing hospitals' costs). The program will compromise beneficiaries' ability to live independently in the most cost effective setting – their homes.

I'm here today to provide information to the Committee about my concerns with the competitive bidding program from my clinical experience in New Jersey, as well as from a national perspective.

Clinical Perspective of Competitive Bidding

As both an Assistive Technology Professional (ATP) and a nurse, I am in contact with patients, the end users of HME, every day and it scares me to think of what will happen to these patients if Competitive Bidding becomes reality. Competition in the marketplace forces me and other HME company employees to provide customers with service and choice, to offer equipment that does not make the most profit but makes the most sense, clinically. Competitive bidding is competition in name only. In fact, it is anti-competitive.

There are over 200 Medicare-approved Group 2 support surfaces. Some cost the provider under \$400, some cost the provider over \$10,000, but the Medicare reimbursement is the same, regardless of the provider's cost.

Currently, HME companies compete for the support surface business and can offer a variety of products to meet customer needs. Under competitive bidding, providers would have to furnish the least expensive product or lose money on every group 2 support surface order. If every patient who needed a group 2 was placed on the least expensive support surface, most of those patients' pressure ulcers would worsen and they would end up in the emergency department or be admitted to hospitals for surgical debridement. I see patients on inferior support surfaces and improper low-end wheelchair cushions get re-admitted to hospitals for pressure ulcers every day. Ordering clinicians stop using the HME company and call a more reliable HME company for the same equipment. Competitive bidding will stop the ordering clinician and patient from making this choice. In these cases, which I believe will be increasingly common under competitive bidding, costs will not only shift from Part B to Part A of the Medicare program, but patient care will be compromised and negative outcomes will become commonplace.

Recently, a New Jersey Rehab Institute ordered a low air loss (LAL) group 2 support surface for a discharged patient with multiple pressure ulcers. We delivered a LAL but the patient's home lost electricity that night and the patient sunk down to the metal bed frame and refused to ever again sleep in a low air loss, yet he needed it for his pressure ulcers to heal. Allcare Medical stocks LAL with solenoid valves that will retain air pressure when electricity fails. These are very expensive units and our reimbursement is actually below our cost, but because we were also supplying the patient with the bed and enteral feeding we were able to provide him with the special LAL. Competitive bidding would preclude providers from providing the best equipment for the patient due to dramatic cuts in reimbursement and the possibility that the company did not win any other bid categories (i.e. beds) to supplement the loss.

Since beds are separately bid from support surfaces, one company may win the bid for hospital beds and another for support surfaces, yet the support surfaces have to be secured to beds and work with the side rails and other bed accessories. Sometimes mattresses have to be removed before the Group 2 support surface can be placed. Patients who require group 2 support surfaces

have pressure ulcers that have worsened over time. They are frequently bedridden but need to be out of bed to take delivery of the support surface. If the bed arrives with no mattress, in anticipation of the support surface, the patient cannot be put to bed. If the support surface arrives before the bed, the support surface cannot be set up and the patient cannot be put to bed. I wonder if the patient can figure out which company to call when the bed is malfunctioning. If the bed-providing practice needs to exchange its bed, they very often will not know how to remove and replace the group 2 support surface, as many require specific calibrations to work effectively.

The Medicare program requires that any HME providing complex rehab employ specialized staff, Assistive Technology Professionals (ATP), to analyze the needs of individuals with disabilities and assist in the selection of the appropriate equipment. The beneficiaries of complex rehab are those with conditions different from the traditional elderly Medicare population. This population group, who tends to qualify for Medicare based on their disability and not their age, consists of individuals with diagnoses of cerebral palsy, muscular dystrophy, amyotrophic lateral sclerosis (Lou Gehrig's disease), spinal cord injury, and spina bifida. This population nearly always requires more traditional equipment as well, such as beds, support surfaces, oxygen, and enteral feedings. Imagine the hospital or sub-acute discharge planner who has to call 5 or 6 companies to coordinate the HME needed for these individuals and the families of these patients who receive bills and EOBs from 5 and 6 companies every month. HME providers provide health care, ours is not a delivery service. Patients know this and they rely on that service provider, not 5 of 6 delivery-service companies.

Respiratory therapists (RTs) evaluate patients to determine the best respiratory equipment that will meet the needs of specific patients. Are they highly ambulatory? Do they require high liter flows? Do they use a PAP device at night with oxygen entrained and O₂ during the day? Can they tolerate a conserving device? RTs will perform pulse oximetry to make sure that the patient does not desaturate if they are using a conserving device or a pulsed dosed system (conserving devices on portable cylinders, portable oxygen concentrator or liquid oxygen system). HME companies are not reimbursed for any of these services. Yet, these are the services patients receive in a competitive environment. These vital services would not likely continue under the competitive bidding scenario.

Credit has also tightened significantly since the collapse of the credit markets in 2008 and businesses are finding it much harder to secure credit. As a result of dramatically reduced reimbursements and profits, many winning bidders will not be able to secure ample credit to support the capital requirements for this new found business. This scenario is very realistic as we are personally experiencing tightening credit even at the current rates of reimbursement. What will happen when many companies cannot obtain the financing and buy the equipment and make the necessary investments to provide to their new captured audience (the patient)?

I am also concerned with the negative impact competitive bidding will have on patient care during a national disaster or weather emergency. Between 4pm and 9pm on August 30, 2010, Monmouth County experienced an extensive power outage affecting more than 70,000 residences. Allcare responded to dozens of calls from oxygen patients (or their caregivers) asking for additional back-up tanks since their electric oxygen concentrators were temporarily not functional. Allcare was able to deliver tanks to dozens of patients within just a few hours of each call. Not one patient ran out of oxygen from their original back-up tanks. What if there

were more widespread outages caused by a natural disaster or even an act of terrorism? How would a limited number of providers be equipped to effectively provide backup tanks needed to potentially thousands of their patients in relatively a few hours? How many hospital admissions would result if these few providers failed to deliver back up tanks timely?

I maintain that what sounds too good to be true, is too good to be true and this ill-conceived anti-competitive program called competitive bidding will single-handedly destroy the home medical services sector which will preclude patients from living safely and independently at home, the best, safest, most preferred and cost effective environment for the patient.

In most cases the prescribers of HME are not familiar with all the HME technology that is available. The ordering clinicians, through trial and error, have come to rely and trust the HME companies they use, to provide their patients with the best equipment for optimal outcomes in the needed time frame. What recourse do the ordering clinicians and patients have if the bid winner cannot offer the products and services they require?

Homecare is the answer to our nation's health care crisis and this bidding experiment is an economically-crippling initiative that will annihilate the slowest growing, most cost-effective, preferred source of care for our society.

I would now like to provide the Committee with my concerns from a national perspective.

Home Medical Equipment is Cost-effective Care for an Expanding Older Population

HME is an efficient and cost-effective way to allow patients to receive care they need at home. Approximately eight million Americans require some type of medical care in the home. Today, virtually any medical procedure short of surgery can be performed in a patient's home. Homecare represents a small but cost-effective portion of more than \$2.3 trillion national health expenditures (NHE) in the United States

The older population in the US is expanding. There were 39.6 million older Americans (age 65 or older) in 2009, representing 12.9 percent of the population in the U.S. There were 4.6 million elderly Americans aged 85 and older. By 2030, there will be about 72.1 million people over 65, more than twice their number in 2000. The population aged 85 and older is the fastest-growing segment of the older population, with a projected increase from 5.8 million in 2010 to 8.7 million in 2030. The need for HME and HME providers will continue to grow to take care of the ever-increasing number of older Americans.

As more people receive good equipment and services at home, we will spend less on longer hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation's healthcare funding crisis. Home medical equipment represents less than two percent of Medicare spending. So while this bidding program may reduce reimbursement rates for home medical equipment, ultimately, it will increase Medicare and Medicaid spending for hospitals, physicians, nursing homes, and emergency treatments.

History of the HME Competitive Bidding Program

Round One Bid Process

The Medicare Modernization Act of 2003 (MMA) requires Medicare to replace the current HME payment methodology for certain items with a selective contracting process. Any provider not awarded a contract will be prohibited from providing bidded Medicare items for the length of the contract, typically a three-year period. The program was slated to go into effect in 10 metropolitan statistical areas (MSAs) across the country, expanding to an additional 70 MSAs in subsequent years. CMS has the authority to conduct additional rounds of bidding in other areas or apply the bid rates from one MSA to an area where bidding did not take place.

The Patient Protection and Affordable Care Act (ACA) further accelerated this implementation by adding an additional 21 MSAs to Round Two and mandating that competitively bid pricing be in place in all MSAs by 2016. This authority is of particular concern because CMS can apply the bid rates from the large MSAs in Round One to smaller urban areas or rural areas where the costs of providing HME items and services to patients may vary significantly. CMS began implementation of the program in 2007.

During the initial Round One bidding process, a significant number of providers who were awarded contracts could not deliver services commensurate with their bids, creating scenarios where beneficiary access to quality home medical equipment and services was reduced. These problems included awarding contracts to inexperienced or non-local providers, unlicensed providers, providers who did not have financial resources to ramp up to deliver services to a larger number of patients, and some “winners” attempting to sell their contracts but failed due to responsible providers not being able to provide the product and service at these bid amounts.

On December 8, 2009, the GAO released a report entitled, ‘CMS Working to Address Problems from Round One of the HME Competitive Bidding Program’. The GAO report said CMS provided unclear and inconsistent information, particularly regarding bidding requirements and financial information. Some bids by equipment providers were incorrectly disqualified. The report further details the lack of notification to providers about the post-bid review process. The GAO report also notes that its report did not identify “concerns with the overall structure and design” of the bidding program because “such an analysis was beyond the scope” of the report.

The problems associated with this process ultimately led Congress to include a provision in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delaying the program in order for CMS to address these issues. To pay for this delay, the HME sector agreed to a 9.5 percent cut in Medicare reimbursement. Unfortunately, CMS ignored the underlying purpose for delaying Round One, which was to give CMS and providers the opportunity to identify and correct the implementation flaws that had plagued the “first” Round One. In passing MIPPA, it was Congress’ belief that § 154(b) would effectively delay a new Round One for a period of at least 18 months, which would be adequate to address the problems that had been identified. When he introduced H.R. 6252 (later incorporated into MIPPA as Sec. 154(b)) to delay Round One, Representative Pete Stark, the sponsor of the legislation in the House, stated:

“Without Congressional intervention, the flawed program begins on July 1, 2008. The bill we’re introducing today delays implementation of the competitive bidding program

for 18 months to provide the Centers on Medicare and Medicaid Services (CMS) with the time to create an improved program based on standards laid out in this legislation.”

Similarly, Senator Charles Grassley introduced legislation with a sense of the Senate provision to delay the competitive bidding program for 18 months. The Grassley bill stated:

“Implementation of competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies should be delayed by 18 months to address concerns and ensure beneficiaries continued access to quality medical equipment and supplies. “

[Statements on Introduced Bills and Joint Resolutions 154 Cong. Rec. S5525-01, S5528)]

In fact, at the time it was passed, § 154(b) was widely understood by both its supporters and opponents as intended to delay competitive bidding for at least 18 months to give CMS an opportunity to make changes in the program. In a statement supporting the President’s veto of MIPPA, Representative Joe Barton stated:

“The bill before us, if the veto is not sustained, would delay-and I’m being charitable to use that verb-the reform of competitive bidding for durable medical equipment. It would delay that for 18 months, which in all probability would kill a program that would save billions and billions of dollars if implemented.”

Medicare Improvements for Patients and Providers Act of 2008-Veto Message from the President of the United States (H. DOC. NO. 110-131) 154 Cong. Rec. H6520-04, H6521).

Floor statements in the House and Senate clearly show Congress’ understanding that §154(b) would delay Round One for at least 18 months. This understanding of §154(b) was so widespread in the days leading up to its enactment, that we were surprised when CMS published the IFR, completely avoiding the requirement to solicit public comments and create an administrative record for the rule. The preamble to the IFR states that formal rulemaking is unnecessary because the statutory requirements of § 154(b) are self-implementing. Even assuming this is correct (which we dispute as we noted above), CMS nonetheless ignored the factual context, which prompted Congress to intervene by delaying Round One.

Congress did not delay Round One for the sake of delay; Congress believed it was giving CMS more time to make meaningful changes to the program. Based on the events precipitating the delay of Round One, it was the belief that at the very least Congress expected CMS to solicit public comments with the goal of improving future rounds of bidding. Instead, CMS has moved forward in a vacuum, incorporating little feedback from stakeholders on how to avoid the mistakes of Round One.

Round One Re-bid Process

On January 16, 2009, CMS released the interim final rule on the competitive bidding program to implement changes to the program. Unfortunately, CMS failed to make any substantive changes to the competitive bidding process. The Agency made only minimal changes required under MIPPA while relying on the original, flawed final rule for the methodologies used in selecting providers and calculating payment rates. This was all done without consulting the PAOC or

allowing for public input. When the competitive bidding rule was released, I anticipated the same problems that plagued the initial roll-out of the program to re-occur.

Examples of Round One Re-bid Problems

- One provider in Texas received an enteral nutrition contract but did not submit a bid for enteral nutrition.
- One provider in Ohio was offered a CPAP contract but does not have a licensed respiratory therapist on staff where it is a requirement to have licensed respiratory therapists to provide CPAP devices.

On July 1, 2010, CMS announced the Round 1 re-bid single payment amounts and touted 32 percent in savings from the competitive bidding process. I am very concerned that these bid rates are unsustainable and will negatively impact patients' access to the home medical equipment that they need.

If the fundamental mechanics, which were not changed, led to the failure at a reimbursement rate reduction at 26 percent before 2008 allowable, why should we expect the program to work with an average 41 percent reimbursement rate reduction? CMS has not provided any substantive information to the public to analyze the Round 1 bid rates. While proclaiming the low bid rates, CMS has failed to provide basic information about the bid process and the HME providers that will be offered a contract.

Although CMS has released little information about the Round One Re-bid process, I was concerned by a statement made by a CMS official about some of the bid winners financial stability. During a press call on July 2, 2010, he stated –

"We do screen bids that are on the low side (to) determine whether or not the provider can actually provide the service or the item at that price," the CMS official said. "That includes looking at invoices...and the provider's financials, including their liquidity and credit, and their ability to expand into a market area. Where we do not feel comfortable, we may not count their capacity at all, or to the degree that they wish us to, in determining the number of winning providers. In fact, we did that 30% of the time. So we have been very careful in selecting providers and in scrutinizing these bids, in terms of prices and sustainability. I think we're comfortable, when we look at the prices that we see."

Round Two Bid Process

CMS is scheduled to begin the Round Two bid process in 2011. Round Two bidding will occur in 91 MSAs and will affect most of New Jersey. I am concerned with the effects this massive expansion of competitive bidding will have on 1.3 million Medicare patients in New Jersey, as well as patients across the county. The following are specific examples of how competitive bidding will affect New Jersey:

- The recent expansion of competitive bidding in the ACA legislation will include 17 out of 21 New Jersey counties in Round Two bidding, which equates to 80 percent of the state. Chairman Pallone's 6th district, which has 86,000 Medicare patients, will be

entirely affected by the bidding program. In less than six months, New Jersey providers will be required to register as bidders, and begin the actual bidding process.

- The recent passage of ACA, a new eligibility group has been added to many state Medicaid programs. In New Jersey it is expected that the Medicaid program will be responsible for ensuring an additional 300,000 - 900,000 lives. While competitive bidding is a program that will immediately impact the Medicare program, caution should be exercised when the reduction of providers is considered. If providers are reduced by approximately 90 percent, this will not only affect the Medicare population, but the Medicaid population as well, creating additional burdens to CMS.
- There are potential job losses of 14,831 in the three overlapping MSAs that will affect NJ, and the potential closure of 1,483 companies, as referenced in "DME Competitive Bidding Will Cost More Than 100,000 Jobs" informational brochure, 2010.
- Credit markets for small businesses remain difficult to access in New Jersey. With the competitive bidding program poised to disallow the participation of an alarming amount of current Medicare providers, bid winners will need to have timely access to lines of credit and small business loans to have the ability to service the increased volume of Medicare beneficiaries. In the current economic climate, it appears these options are not readily available.

Consequences of Bidding

The Medicare bidding program is a poorly conceived and fundamentally flawed program that is now exhibiting many of the serious breakdowns that are predictable based on its failure to recognize and account for the true nature of the way home medical equipment is provided to Medicare beneficiaries. These breakdowns have been evident since the start of the Round One bidding process in early 2007, throughout the bid evaluation process, and right through the recent awarding of contracts. Design and operational problems in the bidding and contracting phase will seriously compromise beneficiary access and quality of care.

The current bidding program will drive thousands of qualified HME providers out of the Medicare marketplace. One of the consequences will be limitations on services available to millions of seniors and people with disabilities.

The Medicare Modernization Act mandated a competitive bidding program to establish market-based pricing for home-based equipment and care under Medicare. But because the bidding system will reduce the number of home medical equipment providers that are currently supported by the marketplace, it will needlessly eliminate thousands of qualified providers, reduce services to beneficiaries, and systematically dismantle the nation's homecare infrastructure.

HME providers are overwhelmingly small to mid-sized practices that typically receive about 40-50 percent of their business from Medicare patients. The loss in the ability to serve this patient population will result in layoffs and many business failures. The term "competitive bidding" is misleading because CMS is radically reducing the number of providers that compete in a given area.

The changes that will result from the bidding program will affect more than three million beneficiaries who reside in Round One areas. CMS has indicated that if Round Two is

implemented, approximately 50 percent of all Medicare beneficiaries requiring home medical equipment could be affected. The bidding program could also quickly affect all Medicare beneficiaries in the U.S. as early as January 1, 2015, when CMS will have the authority to apply bid pricing in non-bidding areas. The ability of CMS to apply bid pricing to non-bidding areas, especially rural areas with hard-to-reach patients, is clearly not market-based.

Impact on Beneficiary Quality of Care

Many Medicare beneficiaries who reside in bidding areas will likely see: (1) a reduction in the level of services they receive; (2) lower quality items that may not be tailored to their specific needs; and, (3) disruptions in continuity of care as they are forced to switch providers.

Under the bidding program, providers are required to provide the same products to Medicare beneficiaries as they provide to non-Medicare patients, but only in situations where a physician specifically prescribes a certain product and brand. In all other cases, providers have the option to provide a range of products that fit within the physician's prescription. With the drastic reduction in reimbursement rates, there will be a diminution in the quality of goods and the level of service that providers have furnished in the past.

Additionally, CMS will have likely awarded contracts to providers who currently have no physical presence in bidding areas. These providers have the following options. They can: (1) quickly form subcontracting arrangements with local providers, or (2) attempt to open a new location(s) to service beneficiaries residing within a bidding area. In either case, providers will have to make these changes in the next four months because the program starts in January 2011.

More than 20 million Americans currently live with diabetes, a serious and chronic disease. One in four Medicare patients suffers from diabetes and these beneficiaries account for 40 percent of Medicare spending. It is likely that a large number of beneficiaries with diabetes will need to switch providers. These new providers may not furnish the testing supplies they currently have. Alternatively, these beneficiaries can go to a local retail outlet when Medicare reimbursement is much higher. Given these statistics, it is imperative that we work to help patients more effectively manage their chronic disease. Reducing the likelihood that diabetes patients will be compliant in managing their disease should not be the byproduct of bidding.

Prior to bidding being implemented, significant policy changes have been slated to take effect that will impact home oxygen beneficiaries. The problems with the 36-month payment cap—which went into effect on January 1, 2009—will only be magnified with bidding and its additional set of rules. For example, a beneficiary who is in his/her 31st month on oxygen therapy with an advanced oxygen system who moves to a new geographic area is unlikely to find an oxygen provider willing to furnish the same level of technology that the beneficiary was previously using.

There is also the real issue of providers being able to ramp up operations to meet significant new demand for medical equipment and services subject to bidding. While CMS has stated it has selected enough providers to service an entire bidding area for each product category, contract providers are going to have to be prepared for a significant increase in demand for these items and services. Based on the information provided by CMS that identifies the number of contracts that were offered in each product category and each bidding area, contract providers could see an

increase of 200-300 percent in the number of patients they are required to serve. Providers may be overwhelmed by the huge increase in volume, which their systems and infrastructure did not anticipate or may not be able to handle. This is especially true for providers who have never operated in bidding marketplaces prior to the implementation of this program. Contract providers that cannot meet demand are unlikely to provide the level of service that patients are accustomed.

These changes will also impact manufacturers who provide providers with lines of credit, which allow them, in turn, to purchase home medical equipment. These manufacturers will experience significant chaos in the credit market. These challenges will only be magnified by the annual tax on medical device manufacturers that was mandated in ACA. Good providers who lost bids will become instant bankruptcy risks for manufacturer creditors because they have no way to anticipate the impact of bidding on providers and their ability to meet payment obligations.

It will also be difficult for manufacturers to provide winning providers with the credit they are seeking given the significant payment cuts. Credit from financial institutions for winning providers who need to increase their operating capacity to meet increased demand also may not be readily available as the financial markets have recently made lending much more difficult. As a result, it will be the beneficiary who may not be able to receive the same quality of items and services that were previously provided due to credit pressures.

Impact on Beneficiary Access to Care

In the initial Round One, some providers were awarded contracts for certain product categories, which they had never before provided. Because of the lack of transparency, we do not yet know if this occurred in the re-bid process. CMS has never outlined how it evaluated a provider's self-reported plans to provide these new services. I also question how these providers could submit accurate bids for such services and items while also incorporating an unknown demand factor and operation costs into their bid calculation.

Consider the range of beneficiaries that will be impacted by bidding effective January 1, 2011:

- More than 220,000 Medicare beneficiaries who currently rely on home oxygen therapy may experience a disruption of their service if their provider does not elect to "grandfather" existing patients, and tens of thousands of new patients prescribed the therapy will have severely limited access from January 1, 2011 forward.
- 143,000 beneficiaries currently receiving home-delivered diabetic supplies may be forced to switch providers by January 1 since there is no "grandfathering" provision. Small "winners" will be overwhelmed by the rush of patients to switch providers by CMS' deadline.
- 10,000 beneficiaries currently receiving home enteral nutrition therapy may be forced to switch providers by January 1 since there is no "grandfathering" provision.

- 16,000 beneficiaries currently being treated at home for obstructive sleep apnea (OSA) may have to switch providers as they assume ownership of their equipment under the Deficit Reduction Act (DRA).
- 25,000 elderly beneficiaries currently relying on hospital beds to remain at home may have to switch if their providers do not “grandfather” due to pricing in one or more markets.

Beneficiaries also are likely to face the prospect of coordinating care with multiple providers in bidding areas. Prior to bidding, a beneficiary’s home medical equipment needs could be served by one provider. Now, providers can only serve beneficiaries for items and services subject to bidding for which they have received a contract. If a beneficiary needs a hospital bed, a walker and oxygen therapy, the beneficiary may require care from three separate providers due to the mechanics of the bidding program.

Few beneficiaries are aware that changes resulting from this program are imminent. If services and quality are reduced, if access is curtailed or beneficiary compliance diminishes—all likely outcomes from this program—Medicare costs will increase as patients require longer hospital stays, seek more frequent physician interaction and have to visit the emergency room more often.

Home Medical Equipment Provider Impact

I believe that the Medicare bidding program will radically change the HME marketplace if implemented in its current form. CMS will selectively contract with only approximately 360 unique provider companies in the first 9 metropolitan areas under the fee-for-service program. CMS’ own statistics have shown that approximately 4,500 unique companies reside in these 9 bidding areas. This would indicate that CMS intends to contract with approximately 8 percent of existing home medical equipment companies. Even if we only account for the unique companies that took part in the program—1,011 companies—CMS is still threatening the financial viability of 64 percent of the otherwise qualified and accredited providers in the current homecare marketplace. Arbitrarily limiting the number of homecare companies that the market will support should be viewed as selective contracting, not competitive bidding.

The integrity of contract providers may also become a question since some providers who participated in the program submitted bids based on the assumption that they would be awarded contracts for multiple product categories subject to bidding. If, for example, a provider submitted its bids expecting to be a contract provider for multiple product categories but only “won” a contract for one product category, the provider’s long-term sustainability may be in question.

Savings Are Questionable

The bidding program designed by CMS is fatally flawed and its widely touted savings are misleading. Smaller providers were fearful that larger providers had a competitive advantage in the bidding system due to the ability of these larger providers to negotiate volume pricing with manufacturers. As a result, smaller providers believed they could only remain viable by bidding at levels that were extraordinarily low, but assumed that larger provider bids would reflect accurate (higher) pricing and would increase the final Medicare single payment amount, thus, rationalizing payments.

Essentially, small providers bid unreasonably low to have an opportunity to "stay in the game" since the alternative is to go out of business. Because so many small providers bid so low, these bidders came close to meeting the capacity projections; preventing many of the larger firms' bids from being considered. I believe the extraordinarily low bid rates will be unsustainable over a three-year contracting period.

The argument that the pricing levels established through bidding are indicative of market pricing is unfounded. The bid system established an elaborate "game" with skewed incentives, resulting in prices that are not reflective of market pricing; but instead were based upon a desperate need to "stay alive" through the bid program.

I anticipate that beneficiaries in the bid areas will receive lesser quality items and reduced services. Also problematic will be beneficiary disruption and confusion that will lead to additional program costs in the form of longer hospital stays, more frequent physician visits and care sought in emergency rooms. The length of hospital stays will increase while case managers/discharge planners are forced to navigate the confusing process of locating "winning bidders" (possibly several for a single patient). This will delay discharge and increase costs for Medicare part A. Also, discharge planners are used to dealing with local HME providers and may be forced to use providers that they are unfamiliar with, as well as providers who are unfamiliar with the normal discharge processes of these facilities. This is also likely to cause confusion and ultimately delay discharge. None of these factors has ever been identified by CMS in its presentation of savings that can be achieved through bidding.

Flawed Structure of Bidding System

The problem with the competitive bidding program, as CMS has implemented it, is that the bid scoring and price formulation procedures are inconsistent with the bidding behavior that CMS wants to encourage. That is, overly complex rules for choosing winners and setting prices distort the incentives that bidders face and may actually result in increased prices for some consumers.

This concept is taken from an article in the Southern Economic Journal, 2008 by professors Brett Katzman from Kennesaw State University and Kerry Anne McGeary from Drexel University.¹ Professor Katzman also released more recent information opposing competitive bidding stating that the net result of the winner's curse is that many of the reimbursement prices will be lower than the needed costs for providing those services and equipment. The winner's curse is where companies that must forecast future costs of [providing equipment and service] when formulating bids are those firms that are likely to make the lowest forecasts.²

¹ Katzman, B, McGeary, K.A. Southern Economic Journal 2008, 74(3), 839-856, p.855.

² Dr. Katzman's research focuses on auction and competitive bidding and has been published in highly ranked peer-reviewed economics journals. His work on Medicare competitive bidding won the prestigious Dr. Katzman's research focuses on auction and competitive bidding and has been published in highly ranked peer-reviewed economics journals. His work on Medicare competitive bidding won the prestigious Georgescu-Roegen Award for best paper in the Southern Economic Journal in 2008. Dr. Katzman has served as an expert witness on competitive bidding in Federal Court and as a bidding consultant to numerous private firms.

From another economist from the Robert Morris University (RMU), the introduction of this kind of program is generally justified by a perceived market failure. Professor Brian O’Roark with RMU states that CMS has not demonstrated any major problems with the current market state. He continues “while this program appeared to encourage competition through bidding, on the supply side the number of sellers of HME were reduced. Since competition is characterized by many sellers, the laudable objective of reducing health care costs through competition seemed to be compromised.”³

Not an Anti-fraud Tool

Some claim that the competitive bidding program may serve as an anti-fraud tool. This notion is misguided. Fraudulent providers who are out to scam the system are not concerned with the level of payment rates. They are typically in collusion with other providers (physicians and/or beneficiaries) to bill for services that are never provided. Regardless of whether HME payments are at current levels or the unsustainably low competitive bidding rates, they can continue to perpetrate fraud because they are not concerned with the costs of legitimately providing quality items and services to beneficiaries. They can afford to bid low enough to receive a contract since they are unconcerned with the costs of doing business. They can continue to provide kickbacks to physicians who order services for beneficiaries who do not require medical equipment and never receive the equipment that is ordered.

Arbitrarily limiting the number of legitimate providers in the marketplace does nothing to keep those whose only intent is to defraud the Medicare program out of the system. CMS has already taken numerous strides to reduce the potential for fraud in the HME benefit. These include requiring mandatory accreditation, mandatory surety bonds, and a recent expansion of the supplier standards that will become effective in a few weeks. This is in addition to the numerous anti-fraud and abuse provisions enacted in the ACA that are just now starting to go into effect

AAHomecare has long advocated for additional anti-fraud provisions that could reduce the number of fraudulent providers while avoiding overly burdensome policies that only hurt the legitimate providers. Unfortunately, the competitive bidding program is just another flawed tool that hurts the providers who seek only to provide quality items and services to Medicare beneficiaries in their homes.

Lack of Government Transparency

The development and implementation of the bidding program have been shrouded in secrecy. Transparency is intended to protect the public. But the lack of transparency masks deficiencies in the program and makes it impossible to evaluate fully the way CMS reached its various decisions at every stage of the process. CMS’ unwillingness to share basic information about the program raises serious questions about any future rounds of the program with respect to fair provider selection and patient access to quality providers.

³ O’Roark, B. Robert Morris University. The Impact of Competitive Bidding on the Market for DME –A One Year Update, August 2009. p. , p. 2.

CMS has not shared meaningful bidding data nor the methodology and criteria used to establish new Medicare payment rates and the criteria by which providers were evaluated. By refusing to release critical data, CMS is impeding an open assessment and dialogue with the public.

How did CMS evaluate the financial stability of providers? How did CMS review a provider's self-reporting capacity to meet the market's need? Did CMS properly calculate the single payment amount? What criteria did CMS use to evaluate bids and determine whether a bid was a "bone fide" one? What process did CMS use to re-evaluate the bidding packages of providers who believe they were inappropriately disqualified from the program? These and other questions still remain unanswered and threaten the integrity of the bidding program. From an administration that touts its openness and transparency, we have seen none of this related to this program.

Conclusion

The fundamental flaws in the bid process still exist, which will jeopardize beneficiary access. Bidders are not bound to their bids; leading to speculative low-ball bids in an attempt to win a contract, and hoping other bidders will increase the bid price. There is no guarantee of volume of need equipment and services, making it impossible to submit a rational bid based on expected volume. CMS has set up a program that will eliminate 90 percent of qualified providers and create an access problem for all consumers of HME, not just Medicare beneficiaries. The program also fosters "suicide" bidding, which results in unsustainable payment rates: If a provider does not secure a contract, its chances of survival are slim. Since Medicare is the largest purchaser of HME items and services, CMS is using economic coercion to force unsustainable bids from homecare providers who are desperate to maintain cash flow in the hopes of staying in business. The program will destroy the current HME infrastructure that allows consumers ready access to quality items and services.

To address the fatal flaws in HME competitive bidding, Congress must immediately stop the implementation of this bidding program and work with the HME community to ensure accurate pricing, while at the same time ensuring access to quality care for Medicare beneficiaries.

Thank you again for the opportunity to provide testimony regarding this important issue. AAHomecare, JAMES, and I look forward to working with the Committee to protect patients' access to the equipment and care they need at home.