



**Statement by Nancy M. Schlichting
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**For the
Committee on Energy & Commerce
Subcommittee on Health
Of the
U.S. House of Representatives**

**Hearing on Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and
Supplies (DMEPOS) Competitive Bidding Program
September 15, 2010**

Chairman Pallone, Ranking Member Shimkus, Congressman Dingell, Congressman Rogers and Members of the Subcommittee,

My name Nancy Schlichting. I am President and CEO of Henry Ford Health System in Detroit, Michigan.

I appear today on behalf of hospitals and health systems that own and operate their own Durable Medical Equipment services. We are deeply concerned about the impact of competitive bidding on our costs and patients, unless the program can be revised to protect our business model. The key feature of our organizations is the ability to integrate and align post-acute care with hospital care.

Over the past three years we have been working in an informal coalition with hospitals and health systems in 22 states that have developed their own DME and other post-acute care services as a way of improving quality and safety for our patients while controlling costs.

For us, Durable Medical Equipment is one of many services housed within our health systems that allow us to manage patient care effectively and efficiently. Henry Ford serves approximately 1 million patients in Southeast Michigan. We own and operate 6 hospitals, 27 regional medical centers and a 500,000 member HMO, which includes about 30,000 Medicare Advantage patients. Our 1,200 Henry Ford Medical Group physicians are salaried, and all business units, including DME, are aligned to coordinate and integrate care at the best price. We function in a very competitive marketplace with growing burdens for uncompensated care.

At Henry Ford, we work to get patients home safely from the hospital as soon as they are clinically ready, so that beds are available for new patients. We work to prevent

readmissions and lower use of the ER. We are able to do this while earning high marks for quality and patient satisfaction. The ability to own and control virtually every aspect of patient care, including DME and other post-acute care services, is essential to our success. Currently the Henry Ford DME services are integrated with Home Health, Hospice and our Nursing Homes. Overall approximately 90% of our Henry Ford DME services go to our own Henry Ford Patients in both hospital and clinic settings.

Members of our Coalition large and small and most are organized similar to Henry Ford. Our Coalition includes the Michigan Health and Hospital Association and many of the nation's premier health systems, such as the University of Michigan and University of Iowa, the University of Pittsburgh Medical Center, the Henry Ford Health System, Advocate Health in Illinois, Aurora Health Care in Wisconsin, BayCare in Florida, the Cleveland Clinic, Banner Health in Arizona and Colorado, Providence in Oregon and Washington, Meridian Health in New Jersey.

We estimate that patient care and costs at more than 200 hospitals would be adversely affected, unless the DME competitive bidding program can be reconfigured.

(A complete listing of Coalition Members is attached.)

I. Do We Oppose Competitive Bidding?

We have not opposed Competitive Bidding. From the beginning, our goal has been to advocate for the right of hospitals and health systems to use our own post-acute care services, including DME, to manage patient care. We have continued to ask for consideration for the DME companies we own and operate, so that we can continue to provide efficient care to our patients at a fair price. The American Hospital Association, Premier, Henry Ford and many other health systems have asked for help with competitive bidding since the rule was adopted in mid-2007. We are willing to accept the pricing determined by competitive bidding, but we question the wisdom of a rule will prevent our ability to own and control post-acute care as a strategy to improve care and reduce costs.

II. Secret of Good Care is in Alignment of Services

In today's hospitals, patient discharges take place throughout the day. We don't keep patients over the weekend, unless medically necessary. In many cases, the ability to send a patient home or into nursing care depends on the availability of numerous items of DME – a hospital bed, surgical supplies, diabetic supplies, a wheelchair, a commode or oxygen. Coordinating the supply and delivery of DME is critical to avoiding extra days in the hospital – extra days that Medicare, Medicaid and private insurers will not pay for immediately. But these costs do get folded into the overall cost of health care.

Where DME and other post-acute care is aligned with the hospital, we can respond to demands of Medicare and private insurers for better care at lower cost, with very high patient satisfaction. Having to use an outside DME company, or several companies in the case of complex patients, destroys this crucial alignment and perpetuates an inefficient and costly business model.

III. Case Studies on Cost

BayCare. During 2008, the HomeCare Division of BayCare Health System in Florida examined 37 cases where hospital discharge did not occur as expected. This was part of an internal Six Sigma study. In every case, delays were associated with an outside DME provider. These delays resulted in 79 additional days in the hospital for these 37 patients. Generally, we estimate approximately \$1,500 per day for extended inpatient stays, including basic hotel services and the unavailability of the room for new paying patients.

Michigan. At the University of Michigan, a retrospective analysis of 1,695 hospital discharges needing home care services was evaluated for the months of October through December 2009. The aggregate median Length of Stay for referrals managed by the hospital-based home care services was 5.3 days, compared to a median of 6.8 days for referrals managed by non-hospital based home care providers (Home Health, DME and Home Infusion). Length of Stay was also higher for specific product lines (Home Health, DME, Home Infusion) where the U of M hospitals were required (by insurance contracts) to use outside suppliers. This study illustrates that hospital-based home care services results in an efficiency of 2,542 inpatient days for this time period. The U of M study estimated a difference in cost of care of at least \$23.4 million. The U of M research also identified higher Emergency Department visits for patients referred to outside home care providers, as well as higher readmissions. (A copy of this research is attached).

III. Who Pays For Extra Cost?

Community costs for health care services concerns us all. This was a prime focus for the Patient Protection and Affordable Care Act adopted earlier this year. Key features of the new law call upon hospitals and health systems to integrate care by aligning services. Health care providers are encouraged to organize Accountable Care Organizations, Medical Homes, Health Innovation Zones in order to push ahead with integration and cost containment. The key strategy to meet these challenges is the close alignment of services and close alignment of incentives among all business units within our own health systems.

Even though extra days in the hospital may not immediately and directly cost Medicare Part A more, the cost for unnecessary days remains in the health system, and eventually everyone pays for it. Savings estimates for competitive bidding focus primarily on price reductions for Durable Medical Equipment under Part B. What is left out of the picture is the increased costs at the hospital and within our health systems.

We believe the competitive bidding program should be structured so that pricing stays the same for all DME providers, but at the same time, retain the ability of our hospital-based companies to serve Medicare patients.

IV. Current Status & Stark Legislation of 2008

Currently, competitive bidding for DME is being rolled out over several years. Phase I was delayed to January 2011 by legislation in 2008 that imposed a moratorium and 10% price cut for DME services.

Under the 2008 law, hospitals were allowed to supply the same DME items that physicians and other practitioners in outpatient clinics are allowed to supply as part of their "professional services." These items are crutches, canes, walkers, glucose monitors, infusion pumps and manual wheelchairs. While we are very grateful to Congress for recognizing that there is a problem under competitive bidding for hospitals and health systems, the new law did not go far enough. The types of services exempted from competitive bidding are not the services we require to manage needs of patients discharged from a hospital stay, or to prevent a readmission or to reduce Emergency Department visits.

A number of large and well-respected health systems in our Coalition are affected by Phase I, which begins January 2011. Very few of our hospital-based companies have been awarded contracts for Medicare patients. Among the health systems now shut out of Medicare for DME services are:

Coalition Member	Products Bid On	Contracts Granted	Hospitals
Cleveland Clinic (Ohio)	3	0	10
UPMC (Pennsylvania)	3	0	13 (20 total)
Carolinas Healthcare (NC, SC)	6	3	10
Advanced HC (NC,VA, TN, SC)	9	3	4 (1,200 beds)
SUMMA (Ohio)	8	3	9
BayCare (Florida)	7	1	N/A (17 Total)

These results will increase go in the wrong direction -- in health systems and hospitals in Phase I, hospital costs will be higher than necessary, and much-needed integration of care between the hospital setting and the home setting will be lost.

Michigan and other states will be included in subsequent roll-out phases of the Competitive Bidding Program.

V. The Solution - Proposed Legislation

We have been advised by CMS that there can be no administrative solution without additional legislation. While we have had good and constructive discussions with CMS, especially on the importance of integrated care as a tool for helping with issues of cost, CMS says that Congress must act.

We have had the pleasure of working with the Chairman Emeritus of this committee, Congressman Dingell and his staff. The bill provides a simple remedy to the problem. Under this bill, qualified health systems that own and operate a DME entity would be

allowed to continue providing DME to its patients and would be reimbursed at the rate determined by the competitive bidding process for its region. Specifically the bill will:

--Allow hospital-based DME companies to continue serving their entity's Medicare patients (inpatients and outpatients);

--Mandate that hospital-based DME companies be compensated at whatever price was established through Medicare's competitive bidding program;

--Ensure that hospital-based DME providers fully meet all credentialing and other requirements for Medicare DME contractors;

--Provide that the exemption would be limited only to those hospital-based DME companies providing such services in May, 2010 or earlier and only to patients of each DME's own health system;

--Allow hospitals and integrated health systems to continue full management of a key element of the hospital discharge, provision of DME services.

According to data available through CMS, we estimate that we represent about 1.5 percent of the market, so market presence is not a significant factor, and should not cause problems for the larger competitive bidding program. We know that there is concern about the competitive bidding process, and this is a larger policy issue for the Congress to determine. Our more limited and focused approach, as contained in Mr. Dingell's bill, H.R. 6095 will allow the competitive bidding system to proceed. It will preserve savings associated with lower prices for DME services. And, it will allow us to preserve a critical patient management tool that is demonstrated to save money and better serve the thousands of patients that come to us for quality medical care every day.

Thank you. I would be pleased to answer your questions.