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3 HEARING ON ``MEDICARE'S COMPETITIVE BIDDING PROGRAM FOR

4 DURABLE MEDICAL EQUIPMENT: IMPLICATIONS FOR QUALITY, COST

5 AND ACCESS''

6 WEDNESDAY, SEPTEMBER 15, 2010

7 House of Representatives,

8 Subcommittee on Health

9 Committee on Energy and Commerce

10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 10:10 a.m.,
12 in Room 2123 of the Rayburn House Office Building, Hon. Frank
13 Pallone, Jr. [Chairman of the Subcommittee] presiding.

14 Members present: Representatives Pallone, Dingell,
15 Eshoo, Green, DeGette, Barrow, Castor, Sarbanes, Sutton,
16 Braley, Doyle, Waxman (ex officio), Shimkus, Hall, Whitfield,
17 Pitts, Burgess, Blackburn and Gingrey.

18 Staff present: Tim Gronniger, Professional Staff

19 Member; Virgil Miler, Professional Staff Member; Alvin Banks,
20 Special Assistant; and Sean Hayes, Minority Counsel, O&I.

|
21 Mr. {Pallone.} I call the meeting of the Health
22 Subcommittee to order.

23 Today the Health Subcommittee will examine Medicare's
24 competitive bidding program for durable medical equipment and
25 its implications for quality, cost and access, and I would
26 yield myself 5 minutes initially for an opening statement.

27 As I think many of you know, durable medical equipment,
28 prosthetics, orthotics and supplies--DME is the acronym--that
29 coverage has been a longstanding issue of this subcommittee
30 and I know it is an issue of great interest to many Members
31 of the House of Representatives. I want to thank our
32 witnesses for being here today, and I am told by my staff
33 that this is one of the most popular hearings she has staffed
34 with a witness list that was hotly sought after.

35 Interestingly, though, I will say, Tiffany, the reason I was
36 late is because I had a political science class from Rutgers,
37 as you know, in my district that was in the office, and they
38 wanted to know why with the--I don't know how they put it--
39 with all the major issues of the day, we were having a
40 hearing on durable medical equipment, and I explained to them
41 that it had a lot of job implications and that we were
42 concerned about jobs and employment, and so then I quieted
43 them down because when I told them that this was a very hotly

44 contested hearing, there would be a lot of witnesses, and
45 people were a little surprised.

46 In any case, I want to especially recognize Karen Lerner
47 and Rich Lerner of Allcare Medical located in my district in
48 New Jersey. Karen will be testifying before us today about
49 the concerns of Medicare's program within the medical
50 equipment community.

51 As you know, the Medicare program covers DME under Part
52 B, the Supplementary Medical Insurance program, and pays
53 suppliers according to a fee schedule. Commonly furnished
54 items under this benefit include standard and power
55 wheelchairs, oxygen concentrators and tanks, hospital beds,
56 diabetic testing supplies and walkers. These and other DME
57 items are essential treatment to allow the approximately 9.85
58 million Medicare beneficiaries with disabilities and other
59 conditions to improve or maintain their health and to live
60 independently at home.

61 Over the past several decades, numerous reports have
62 documented overpayments in the DME fee schedule under
63 Medicare. As such, Congress acted to limit these costs by
64 creating a demonstration of the competitive bidding program
65 in 1997. Its evaluation resulted in reduced costs to
66 Medicare by 19 percent with no significant changes in access
67 to supplies or changes in utilization were observed.

68 Subsequently, the Medicare Prescription Drug,
69 Improvement, and Modernization and Act of 2003, which many of
70 my colleagues on this side voted against, mandated that CMS
71 adopt competitive bidding-based pricing for DME on a phased-
72 in basis beginning in 2007. The Act mandated two rounds of
73 bidding in MSAs, followed by optional additional MSAs after
74 those rounds. As I, along with my colleagues witnessed,
75 there were many problems with the initial implementation,
76 coupled with broad industry concerns. This resulted in a
77 bill that I led through Congress to both delay implementation
78 and established some of the reforms that are supposed to be
79 part of the program today.

80 Let me just briefly say that I have been skeptical of
81 this program in the past, and I am anxious to hear from CMS
82 about how this program is being run and, of course, how the
83 round one re-bid is developing.

84 That being said I am also aware of the fact that CMS is
85 carrying out the law as instructed by Congress. I know very
86 well the concerns of the DME suppliers and it is my hope that
87 CMS has done their best to address some of them. I think
88 today will allow us to hear more about what CMS has done and
89 continues to do to ensure that this program successfully
90 reduces costs to Medicare but maintains access and quality
91 care for Medicare beneficiaries.

92 It is obvious we cannot ignore what will become clear
93 here today, and that is, there remains a large constituency
94 that is simply opposed to this program, but meanwhile, the
95 fear of tremendous consequences persists from both industry
96 and from Members off Congress. So, regardless of where this
97 committee falls, it is our job to keep a watchful eye of its
98 development and be on guard to make changes if necessary.

99 My Rutgers class that caused me to be a little late
100 today was very concerned about Congress exercising its
101 oversight authority, that somehow over the last generation or
102 so we have not done enough for oversight, so I think we do
103 need to do a lot of oversight and this is obviously part of
104 that effort.

105 [The prepared statement of Mr. Pallone follows:]

106 ***** COMMITTEE INSERT *****

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107 Mr. {Pallone.} With that, I yield to the gentleman from
108 Kentucky.

109 Mr. {Whitfield.} Mr. Chairman, thank you very much, and
110 we look forward to this hearing, the opportunity to examine
111 the impact of Medicare's competitive bidding program for
112 durable medical equipment, and before I make a few comments
113 about that, I would like to in a very respectful way touch on
114 some of the questions that your Rutgers political science
115 class were asking you.

116 All of us just came back from a 3-week district work
117 period, and practically everywhere we went, people were
118 asking questions about the recently passed health care bill,
119 and almost all of them were unanimous in the fact that they
120 did not understand the bill. They did not know when
121 regulations were to be expected, when the bill would be
122 completely into effect, and asking all sorts of questions
123 that we really could not answer, and I genuinely believe it
124 would be to the benefit of the American people if this
125 committee did start having some oversight hearings on that
126 legislation because it impacts every single person in this
127 country, and I don't know of any legislation that has passed
128 the Congress since I have been here in which people have been
129 more confused than on this piece of legislation. And I know

130 that the gentleman has the same concerns that I do but I do
131 hope that we would have an opportunity to start having some
132 hearings about that legislation.

133 Today we are very much interested in learning how this
134 new competitive bidding program, this pilot project, is it
135 really going to save Medicare money, and if it does, are we
136 going to be able to maintain the quality of care for the
137 beneficiaries, and I don't think there is any question but
138 that we recognize in the long term we do have to do something
139 about Medicare cost, not just for the fact of saving money,
140 but if we are going to continue to have a viable health care
141 system for our senior citizens, we have to be concerned about
142 the quality of care as well as the price. And many experts
143 that I have talked to, and I am certainly not an expert
144 myself and I really don't have any opinion about this pilot
145 project yet, but many of the experts have said that they
146 believe that this pilot program is poorly designed. They say
147 they have concerns that the entire program could collapse
148 under its own weight, resulting in drastically reducing the
149 number of health care providers in rural areas particularly
150 as well as instead of decreasing cost increasing cost. By
151 having a 3-year contract combined with the fact that
152 relatively few providers are deemed winners results in fewer
153 competitors the next time that bidding occurs because there

154 is going to be a lot of people who will probably get out of
155 this business.

156 But less competition also in the future may very well
157 result in higher prices in the future and mitigate the
158 projected savings by CBO. And as I said, we all are very
159 much interested in solving some of these problems of cost and
160 improving quality of care. And I don't intend to be negative
161 about this today but I am delighted that we are having the
162 hearing to have a better understanding of really is this
163 going to work and is it going to be effective.

164 And then I might also say recently some of us sent a
165 letter to CMS asking that they provide a list of the winning
166 bidders that won the first round of bids so that Congress
167 might have the opportunity to examine those bids to see if
168 those winners are in fact capable of participating in the
169 program, and we only sent that letter a couple weeks ago so
170 we have not had a response yet.

171 But I want to thank you again, Mr. Chairman, for the
172 hearing and I look forward to the testimony of our witnesses
173 who I know will provide us with information that we need to
174 get an objective view of this program.

175 [The prepared statement of Mr. Whitfield follows:]

176 ***** COMMITTEE INSERT *****

|
177 Mr. {Pallone.} Thank you, Mr. Whitfield.

178 The chairman of the committee, Mr. Waxman.

179 The {Chairman.} Thank you, Chairman Pallone for holding
180 today's hearing on this important topic.

181 The health reform legislation contains many essential
182 innovations to improve the quality and efficiency of care in
183 Medicare and in fact the whole entire health care system.
184 Today we are discussing an innovation that predates health
185 reform: competitive bidding for durable medical equipment.

186 The DME benefit in Medicare is an essential benefit for
187 the nearly 10 million seniors who use it ever year. It pays
188 for wheelchairs to help seniors and persons with disabilities
189 move around their homes and communities. It covers diabetic
190 testing equipment so that beneficiaries can manage their
191 condition and avoid kidney failure or heart disease.

192 DME is an indispensable part of an indispensable
193 program. And yet, for many years, payments for DME in
194 Medicare have been the source of seemingly endless problems.
195 DME has received some truly remarkable overpayments. Take,
196 for example, Medicare paying 10 times the purchase cost for
197 oxygen equipment, and DME suppliers billing the program
198 without even staffing their offices or documenting their
199 claims gave us last year's famous ``60 Minutes'' program on

200 Medicare fraud.

201 These chronic problems are an embarrassment to a program
202 that has been, and must continue to be, a model for efficient
203 health care purchasing. Many suppliers are legitimate,
204 honest businesspeople trying to deliver the best care they
205 can to Medicare beneficiaries. Their reputations are
206 unfairly tarnished by the behavior of some of the other
207 suppliers.

208 Congress has acted many times to try to address these
209 problems. Some of these reforms have been successful, and
210 some of them are just getting started.

211 Competitive bidding for DME is a market-based,
212 bipartisan idea. It has been tested successfully in Medicare
213 in demonstration programs under Presidents Clinton and Bush.
214 And it was enacted for program-wide adoption in the Medicare
215 prescription drug bill passed by a Republican Congress and
216 signed by President Bush.

217 This current round of competitive bidding is a re-bid of
218 round one, which was delayed in 2008. I supported that delay
219 because of implementation problems identified at that time.

220 Acting under Congress's direction, the Centers for
221 Medicare and Medicaid Services made many improvements to the
222 re-bid of round one. Those changes appear to have reduced
223 confusion among suppliers, though not opposition.

224 I take seriously the concerns raised by the supplier
225 community regarding potential threats to beneficiary access
226 to high-quality DME. Competitive bidding has been tested
227 successfully in Medicare, but not on a scale as large as what
228 the law requires CMS to implement over the next few years.

229 It is essential that we on this committee continue to
230 monitor developments in this competitive bidding program as
231 it unfolds. That is why I appreciate Chairman Pallone's
232 initiative in calling this morning's hearing.

233 It is also essential that CMS aggressively pursue
234 supplier and beneficiary education efforts in the time before
235 January 1, so as to minimize disruption to care with the
236 start of the New Year.

237 But I question those who say that we need to repeal the
238 program now because of speculative threats to beneficiary
239 access in the future. Where is the evidence for such a
240 threat? It is certainly not found in previous experience
241 with competitive bidding in the Medicare program.

242 Tellingly, those most concerned about beneficiary
243 access--the beneficiaries themselves, including AARP and the
244 Center for Medicare Advocacy--support going forward with the
245 program and vigorously monitoring its execution.

246 Based on what we've heard so far, it appears that the
247 current round of competitive bidding will save beneficiaries

248 significant amounts of money in cost-sharing and premiums.
249 Beneficiaries using oxygen concentrators over a 3-year rental
250 period would save \$400. And the improvements made by
251 Congress and CMS offer important guarantees that winning
252 suppliers will be able to the deliver items and services
253 beneficiaries need. For these reasons, I am cautiously
254 optimistic that competitive bidding for DME may soon begin to
255 finally achieve its promise of reducing Medicare spending
256 while maintaining or improving the quality of care received
257 by beneficiaries.

258 I would also like, Mr. Chairman, to ask unanimous
259 consent to add to the record this statement from AARP that
260 supports competitive bidding so long as it does not
261 compromise quality and access for Medicare beneficiaries.

262 Mr. {Pallone.} Without objection, so ordered.

263 [The information follows:]

264 ***** COMMITTEE INSERT *****

|

265 The {Chairman.} And look forward to this morning's
266 hearing.

267 [The prepared statement of Mr. Waxman follows:]

268 ***** COMMITTEE INSERT *****

|
269 Mr. {Pallone.} Thank you, Mr. Chairman.

270 Next is the gentleman from Georgia, Mr. Gingrey.

271 Dr. {Gingrey.} Mr. Chairman, thank you.

272 As far back as the Balanced Budget Act of 1997, Congress
273 has attempted to address the cost of durable medical
274 equipment on American taxpayers. In large part,
275 Congressional action was prompted by investigations that
276 highlighted a Medicare program paying way above market prices
277 for certain durable medical equipment items. Such
278 overpayments may be due to a Medicare fee schedule that is
279 outdated, lacking what MEDPAC calls ``the invisible hand of
280 market forces'' that can keep costs down. This antiquated
281 system hurts our taxpayers. It makes it hard for seniors to
282 find a provider or a service when sick and it undercuts
283 financial solvency of the Medicare program.

284 The mechanism passed to correct this payment issue, the
285 DME competitive bidding program, was passed with bipartisan
286 support in Congress. However, some concerns arose with the
287 manner in which CMS was conducting the program and some
288 businesses were disadvantaged. I am sensitive to those
289 concerns as I believe that DME companies should be
290 competitive with market prices and not be protected by
291 government rates at the expense of we, the taxpayer.

292 However, I also believe that government programs should
293 allow DME companies to compete and not completely block the
294 market to so many, particularly the small entrepreneurs.
295 These are the principles of a free market economy that MEDPAC
296 suggests Medicare lacks and principles I believe we should
297 all support.

298 Therefore, I want to thank Chairman Pallone for calling
299 this hearing today and I certainly look forward to hearing
300 from our witnesses.

301 That being said, Mr. Chairman, I would like to ask again
302 that this committee call a hearing on Obamacare as soon as
303 possible because the news of its impact on Americans is
304 getting worse. Just this week, Secretary Sebelius sent a
305 letter to various health insurers condemning them for almost
306 double-digit premium increases for the coming year. In that
307 letter, the Secretary called reports of planned premium
308 increases to reflect the new mandated benefits in the law,
309 and I quote ``misinformation and unjustified rate increases."
310 Mr. Chairman, I think it is important that we figure out what
311 is going on here. Why are health insurers raising costs by
312 10 percent if Obamacare is supposed to reduce cost? An op-ed
313 in the Wall Street Journal on Monday states that, and I
314 quote, ``The tone of Ms. Sebelius's letter suggests that she
315 doesn't understand that if Congress mandates new benefits,

316 premiums will rise.''

317 Mr. Chairman, my question is this: Is Secretary
318 Sebelius looking out for the American patients or is she
319 covering up the fact that Obamacare is making their health
320 care unaffordable? I believe the American people and this
321 Congress deserve to know whether these huge rate increases
322 are the work of bad insurance companies or the result of
323 Obamacare. This committee did not shy away from vilifying
324 insurance companies in the past. I see no reason why it
325 should shy away from holding a hearing on this issue now.

326 With that, Mr. Chairman, I yield back my time.

327 [The prepared statement of Dr. Gingrey follows:]

328 ***** COMMITTEE INSERT *****

|
329 Mr. {Pallone.} Thank you.

330 Next is the gentleman from Texas, Mr. Green.

331 Mr. {Green.} Thank you, Mr. Chairman, for holding the
332 hearing today on Medicare's competitive bidding program for
333 durable medical equipment.

334 Medicare Part B covers a wide variety of durable medical
335 equipment that is prescribed by physicians for beneficiaries
336 including prosthetics, orthotics, oxygen, wheelchairs,
337 diabetes testing strips, medical dressings and other various
338 medical supplies. According to the Congressional Research
339 Office, in April 2009 there were 107,000 durable medical
340 equipment suppliers in the United States with Medicare
341 billing privileges. Medical expenditures for durable medical
342 equipment were \$10.6 billion in fiscal year 2008. In 2009,
343 approximately 9.85 Medicare beneficiaries used Medicare-
344 covered durable medical equipment.

345 In general, Medicare pays for durable medical equipment
346 on a fee schedule updated each year by inflation. However,
347 several reports including investigations by the GAO, MEDPAC
348 and the Office of Inspector General have shown Medicare pays
349 above market prices for certain items of durable medical
350 equipment. These overpayments have been linked in part to a
351 fee schedule payment system which does not take into account

352 market changes.

353 To remedy these systematic overpayments, two
354 demonstrations were conducted and a new system of competitive
355 bidding for durable medical equipment. However, this new
356 system implemented in 2007 by MMA was unsuccessful in
357 monitoring, causing confusion among suppliers including CMS
358 delaying the bid window, providing unclear instructions to
359 bidders and electronic document systems that failed and
360 failed to notify suppliers when bidding was complete. This
361 caused Congress in 2008 to halt the program until 2009 so CMS
362 could resolve the issues within the competitive bidding
363 program.

364 CMS allowed suppliers to submit new bids for the first
365 round re-bid in late October 2009 until December 2010, and in
366 July 2010 announced initial payment amounts and contract
367 winners. Final contracts and lists of suppliers of the first
368 round of re-bidding will be announced this fall and contract
369 will go into effect in January.

370 I think this hearing is especially important because
371 Congress has so many concerns with the initial bidding
372 process, and we want to ensure that the next go-around will
373 be successful. We want to ensure Medicare Part B
374 beneficiaries continue to have access to durable medical
375 equipment. We also want to ensure we are not raising their

376 premiums because of the waste or fraud in the system or
377 because of overpricing. All new programs and systems have
378 some problems that need to be addressed. Hearings like this
379 are important because we have the duty to ensure
380 Congressionally implemented programs are working and
381 benefiting many Americans.

382 I look forward to the testimony today and I want to
383 thank the witnesses for taking the time to appear, and Mr.
384 Chairman, I yield back my time.

385 [The prepared statement of Mr. Green follows:]

386 ***** COMMITTEE INSERT *****

|
387 Mr. {Pallone.} Thank you, Mr. Green.

388 The gentleman from Pennsylvania, Mr. Pitts.

389 Mr. {Pitts.} Thank you, Mr. Chairman.

390 Medicare generally pays for most durable medical
391 equipment--prosthetics, orthotics and supplies--on the basis
392 of fee schedules. Unless otherwise specified by Congress,
393 fee schedule amounts are updated each year by a measure of
394 price inflation. However, investigations have shown that
395 Medicare pays above market prices for certain DME items.

396 The Medicare Modernization Act of 2003 established a
397 competitive bidding program for certain DME items which began
398 in 2008 only to be halted days later due to implementation
399 concerns. All contracts with suppliers were terminated and
400 round one of the competitive bidding program had to be re-
401 bid. The second round of bidding is schedule to begin early
402 next year.

403 CMS now estimates that Medicare will pay on average 32
404 percent less for items in the competitive bidding program
405 than it would pay for those same items under the current fee
406 schedule. However, patients and suppliers have concerns that
407 the competitive bidding process will reduce access to quality
408 items and squeeze smaller suppliers out of the market.

409 I would like to hear from our Administration witnesses

410 and stakeholder witnesses on how they view the program and
411 how Congress can make improvements to ensure that patients
412 have access to DME items they need while Medicare isn't
413 overcharged.

414 This is a very important hearing. I look forward to
415 hearing the testimony. Thank you, and I yield back.

416 [The prepared statement of Mr. Pitts follows:]

417 ***** COMMITTEE INSERT *****

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418 Mr. {Pallone.} Thank you, Mr. Pitts.

419 Our chairman, Chairman Emeritus, Mr. Dingell.

420 Mr. {Dingell.} Mr. Chairman, thank you, and I commend
421 you for this hearing and I thank you for holding it. A
422 number of us on the committee requested it because of our
423 concern about whether or not the competitive bidding program
424 is going to in fact work.

425 First of all, it has, as you know, proven to be a very
426 controversial topic, not just among the members of the
427 committee but amongst suppliers, beneficiaries and providers
428 across the country. In the midst of all of this back and
429 forth, I am hopeful that the two sides can agree on two
430 important points: one, the pricing and integrity issues in
431 the Medicare DME are a cause for concern and need to be
432 addressed for the sake of the fiscal future of Medicare and
433 to hold down the costs for beneficiaries, and second, when
434 legitimate problems with implementation of the competitive
435 bidding program are identified, that Congress has acted to
436 address these problems.

437 Today's hearing is going to give us a good opportunity
438 to assess the current state of the Medicare DME competitive
439 bidding program, its cost and the impact on the impact on
440 cost and quality and access and lessons learned and

441 opportunities for improvement. We should have a clearer
442 understanding of what, if any, changes should be made in the
443 program as it is expected to expand.

444 Though this morning's hearing is not specific on any
445 particular piece of legislation, I must mention the
446 legislation that I introduced last month to address a very
447 legitimate concern raised by hospitals in Michigan and others
448 throughout the country. Many hospitals have developed their
449 own DME companies in an effort to better integrate hospital
450 care and support the efficient management of the discharge
451 process. I am concerned that the competitive bidding program
452 threatens the ability of hospitals to continue to operate.
453 H.R. 6095 would allow the hospital-based DME providers to
454 continue serving their entity's patients while being at the
455 same time compensated at the competitively bid rate.

456 Let me make two things very clear. First, H.R. 6095
457 would require those hospital-based DME providers to pay these
458 prices negotiated through the competitive bidding process,
459 and two, the providers would be only allowed to supply
460 patients of their hospital or affiliated physicians. H.R.
461 6095 enjoys the support of the American Hospital Association
462 and the Premier Health Care Alliance.

463 Mr. Chairman, I ask unanimous consent to have the letter
464 from AHA and Premier in support of H.R. 6095 inserted into

465 the hearing record.

466 Mr. {Pallone.} Without objection, so ordered.

467 [The information follows:]

468 ***** COMMITTEE INSERT *****

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469 Mr. {Dingell.} I have the particular pleasure to
470 welcome Nancy M. Schlichting to the committee this morning.
471 Nancy is an extraordinarily capable woman. She is the
472 President and Chief Executive Officer of Henry Ford Health
473 System, one of our Nation's premier health care providers.
474 For many years Henry Ford has been committed to improving the
475 health and well-being of the diverse Michigan community.
476 Nancy Schlichting and the Henry Ford Health System has been
477 an enormously valuable resource to us in Michigan and to me
478 on many important health issues, and I am sure she will prove
479 herself to be every bit as valuable to the members of this
480 committee on this important issue.

481 I want to thank you again, Mr. Chairman, for obliging my
482 request to have Ms. Schlichting with us today and I know she
483 will be bringing much value to this very important hearing.

484 I thank you, and I yield back the balance of my time.

485 [The prepared statement of Mr. Dingell follows:]

486 ***** COMMITTEE INSERT *****

|
487 Mr. {Pallone.} Thank you, Chairman Dingell.

488 The gentleman from Texas, Mr. Burgess.

489 Dr. {Burgess.} Thank you, Mr. Chairman.

490 This provision created in the Medicare Modernization Act
491 to create the competitive bidding program, it is hard to say
492 you don't support the goals of fair and equitable pricing for
493 medical devices for patients and at the same time reducing
494 inappropriate transfers. Certainly the idea holds promise
495 and takes the fundamental free market principle and puts it
496 into practice, allowing businesses to compete to general cost
497 savings.

498 We all know something needed to be done prior to the
499 Medicare Modernization Act. The work of this committee
500 demonstrated that Medicare beneficiaries were paying prices
501 that were frankly too high. However, the execution of this
502 attempt to address a very real problem has created problems
503 of its own. To say that the program was poorly executed
504 would be being unnecessarily kind. Fault lies with CMS. The
505 Government Accountability Office has found widespread
506 challenges to suppliers, and I am quoting here, ``including
507 poor timing and lack of clarity in bid submission
508 information, a failure to inform all suppliers that losing
509 bids could be reviewed, and an inadequate electronic bid

510 submission system.' ' Reports of winners who were unlicensed
511 and unaccredited and realistically unable to serve a
512 geographical region and showed a widespread reduction in the
513 majority of providers in each of the competitive bidding
514 areas. A fee schedule based on these bids thus really cannot
515 be considered to be a valid fee schedule at all.

516 The first attempt at round one ran for 2 weeks. It was
517 stopped by Congress famously on July 15, 2008, because of
518 some of these concerns. The Government Accountability Office
519 called these results unclear and inconsistent. However, when
520 round one was restarted, for many it was more like getting to
521 replay the same hand of cards when everyone knew what
522 everyone else's cards were. So it really was a process that
523 was deeply flawed.

524 I do not believe it is Congress's jobs to guarantee a
525 business's income. At the same time, a winner unable to
526 complete the job drives out competitors and leaves the
527 beneficiary with nothing. What the program was supposed to
528 accomplish was equal access for lower cost, and it really
529 looks as if the Center for Medicare and Medicaid Services
530 didn't take the first part of that equation seriously at all.
531 CMS should look at a company's previous year's market share
532 and geographic reach when considering awarding contracts
533 while allowing for desired company growth. However, it is my

534 guess that a company that is accustomed only to serving, say,
535 a very small town in my district may not be able to service
536 the entire DFW metroplex overnight. It is a simple condition
537 we call common sense.

538 Now, Congress will have to explore what is the best
539 policy to contain cost while not threatening access. That
540 may mean a new policy or it may just mean that Congress needs
541 to stay out of the way and see if the market can adapt to the
542 CMS rules, knowing that we will not interfere. I am not sure
543 which direction is best at this point but I certainly look
544 forward to our witnesses for guidance.

545 Mr. Chairman, I would also ask unanimous consent for
546 testimony for the record from ConvaTec, a medical device
547 company specializing in osteotomy care and wound
548 therapeutics, be entered into the record.

549 Mr. {Pallone.} Without objection, so ordered.

550 [The information follows:]

551 ***** COMMITTEE INSERT *****

|

552 Dr. {Burgess.} Thank you.

553 [The prepared statement of Dr. Burgess follows:]

554 ***** COMMITTEE INSERT *****

|
555 Mr. {Pallone.} Thank you, Mr. Burgess.

556 Next is our colleague, the gentlewoman from Colorado,
557 Ms. DeGette.

558 Ms. {DeGette.} Thank you, Mr. Chairman. We are all a
559 little rusty coming back after 6 weeks.

560 I am really happy also that you have had this hearing
561 today, and truly I am looking forward to hearing the
562 testimony because like all of the members of this committee,
563 we are concerned about saving money for our seniors and we
564 are also concerned about the investigations that show that
565 Medicare pays above market prices for certain durable medical
566 equipment. And the competitive bidding demonstration did
567 result in a savings but on the other hand, there are a lot of
568 anxieties about implementation and the expansion from nine to
569 an additional 80 areas including my district of Denver most
570 likely, and the round one bidding process had a lot of
571 complications, as we have heard from our colleagues. So we
572 need to make sure that the guidelines for suppliers and
573 information disseminated to beneficiaries is clear and
574 consistent before we expand the bidding process, and we also
575 have to ensure that Medicare beneficiaries can receive the
576 same quality of medical equipment that they are accustomed to
577 and also we need to make sure that we have enough suppliers.

578 So there are a lot of issues here and I am glad you are
579 having this hearing so we can begin sorting them out, and I
580 yield back the balance of my time.

581 [The prepared statement of Ms. DeGette follows:]

582 ***** COMMITTEE INSERT *****

|
583 Mr. {Pallone.} Thank you.

584 The gentlewoman from Tennessee, Ms. Blackburn.

585 Mrs. {Blackburn.} Thank you, Mr. Chairman. Thank you
586 for the hearing today.

587 You know, Medicare's competitive bidding program for
588 durable medical equipment has been contentious, to say the
589 least, and many issues in this competitive bidding program
590 are worthy of discussion and should be discussed. We need to
591 talk about access, transparency, accountability and the
592 impact on small businesses, and many of my constituents have
593 very grave, solid and valid concerns on the implementation of
594 the program.

595 While the DME issues are worthy of discussion, we
596 continue to hear disturbing news about the implementation of
597 Obamacare. News broke last week that I believe deserves
598 urgent attention from this committee. Public opinion is
599 heavily against the program. The Obama Administration is
600 dealing with fuzzy math regarding soaring health care costs,
601 and Health and Human Services Secretary Sebelius is trying to
602 bully insurance companies into submission.

603 Now, since that bill passed, we have had 15 Health
604 hearings, seven O&I hearings, and not one of those, Mr.
605 Chairman, has been on the implementation of Obamacare. We

606 need to remedy that.

607 Last week, Secretary Sebelius sent what I think is a
608 fairly threatening letter regarding rate increases resulting
609 from new regulations and mandates in Obamacare. Apparently
610 insurers aren't supposed to explain the cause and effect of
611 that program to their consumers including rate increases with
612 1 percent upwards to 16 percent in some areas. The
613 Administration's attempt to muzzle private companies from
614 explaining to their customers such rate increases as a result
615 of Obamacare I find to be the height of hypocrisy and
616 irresponsibility. That anyone is surprised that costs are
617 rising rapidly under Obamacare is beyond me. We are talking
618 basic economics, the laws of supply and demand. There is no
619 such thing as free care. It has to come from somewhere and
620 it has to be paid by someone.

621 As I have detailed in countless hearings, we tried this
622 in Tennessee. I have tried to explain this to the President,
623 to the Secretary and my colleagues on the other side of the
624 aisle. TennCare was supposed to expand coverage and save
625 money. In 10 years, it nearly bankrupted the State of
626 Tennessee. TennCare didn't save money. It didn't expand
627 coverage as promised and ultimately more than 100,000 people
628 had to be removed from that program.

629 As Tennessee learned, comprehensive health care packages

630 for all will not also be affordable. Government's resources
631 to provide care are fixed. As we learned, intervention can
632 exacerbate rather than control the growing costs of health
633 care. I would love to see us reviewing this issue.

634 I yield back.

635 [The prepared statement of Mrs. Blackburn follows:]

636 ***** COMMITTEE INSERT *****

|
637 Mr. {Pallone.} Thank you, Ms. Blackburn.

638 Next is the gentleman from Georgia, Mr. Barrow.

639 Mr. {Barrow.} I thank the Chair. In the interest of

640 time, I would like to ask unanimous consent to have 5

641 legislative days to submit my statement for the record.

642 Mr. {Pallone.} Without objection, so ordered.

643 Mr. {Barrow.} Thank you.

644 [The prepared statement of Mr. Barrow follows:]

645 ***** COMMITTEE INSERT *****

|
646 Mr. {Pallone.} And next is the gentleman from Texas,
647 Mr. Hall.

648 Mr. {Hall.} Mr. Chairman, thank you, and thanks for
649 having the hearing.

650 The issue of most concern to me is the lack of
651 accountability. When an out-of-area and inexperienced
652 provider can be in any area they choose, undercut the market
653 and withdraw from the program without any repercussion is
654 very, very disturbing.

655 But what is stunning is that CMS, I am told, then used
656 the abandoned low bids as a new rate and required other so-
657 called winners to adhere to a bid that they did not make.
658 CMS claims that it is a market-based program but contrary to
659 their claims, providers are forced lest they close their
660 business to accept prices 20 to 50 percent of what they bid.

661 Many are closing their doors and some are accepting
662 contracts for the sole purpose of staying in business with no
663 profit or at a loss until the program fails and the proper
664 health care can be restored. These are not proper business
665 practices and the program was never intended for this
666 scenario.

667 It must be noted how flawed the program is when the
668 Nation's largest provider, Lincare, put out a press release

669 stating that they were offered contracts over 20 percent less
670 than their bids if they would accept the contracts even
671 though they would lose money on each Medicare patient and
672 would have to supplement these patients from the income they
673 received from other non-Medicare patients. I would like to
674 submit this press release in the record with your permission,
675 Mr. Chairman.

676 Mr. {Pallone.} Without objection, so ordered.

677 [The information follows:]

678 ***** COMMITTEE INSERT *****

|

679 Mr. {Hall.} Transparency of the bidding program has a
680 major problem throughout this process. CMS has refused to
681 release the names of the companies that set the bid rate.
682 This information is necessary so it can be determined if
683 those companies are local or out of the area, experienced, or
684 if those companies are financially viable. Without
685 transparency, the program cannot be fairly evaluated and the
686 bids must be circumspect. CMS seems to be hiding the many
687 known flaws and problems until after the program is
688 implemented.

689 Here is a letter that I along with 135 of my colleagues
690 sent to CMS requesting their names of the winning bidders,
691 and here is CMS's response denying our request. With your
692 permission, Mr. Chairman, I would like to submit these into
693 the record.

694 Mr. {Pallone.} So ordered.

695 [The information follows:]

696 ***** COMMITTEE INSERT *****

|

697 Mr. {Hall.} CMS has claimed that they have performed
698 the diligence on providers and have assured that bidders are
699 financially qualified yet certain companies were able to win
700 bids that averaged 30 percent below their current rates, even
701 though at current rates they are on the verge of bankruptcy.
702 In fact, when asked about the questionable financial
703 viability of companies who were awarded bid contracts,
704 Laurence Wilson of CMS stated on the record that 30 percent
705 of the bidding companies had questionable financials but CMS
706 allowed them to proceed through the process.

707 This disregard for their own directives reveals much
708 about the flaws in the bidding program. CMS has allowed bid
709 rates to be created that are functionally unviable. The
710 average single payment amount for portable oxygen, oxygen
711 tanks that allow patients to leave their homes and lead a
712 normal life, is averaging \$21 a month while the actual cost
713 to provide a liquid portable system is over \$100 a month. An
714 additional oxygen delivery service cost brings the actual
715 monthly cost to over \$150 a month. Providers will have no
716 choice but to stop providing liquid oxygen, which will result
717 in the suffering of patients.

718 In a similar vein, diabetic supply price reductions are
719 averaging over 54 percent of their current reimbursement. No

720 industry in America can survive such a cut.

721 In closing, I will just stay at best that CMS required
722 cut will mean that only foreign-made supplies with less
723 reliability will be used by Medicare patients. American-made
724 products will no longer exist. An immediate service which is
725 often required by patients will be replaced by ground freight
726 delivery. This is disgraceful.

727 Thank you again for having this hearing today and I
728 yield back the balance of my time.

729 [The prepared statement of Mr. Hall follows:]

730 ***** COMMITTEE INSERT *****

|
731 Mr. {Pallone.} Thank you, Mr. Hall.

732 Next is the gentleman from Iowa, Mr. Braley.

733 Mr. {Braley.} Competitive bidding. It sounds like it
734 would be un-American to oppose something that sounds so
735 important and yet competitive bidding will lead to the now-
736 disproven model of too big to fail in the durable medical
737 equipment industry because companies that can lower margins
738 and try to make it up on volume are going to drive providers
739 out of the market in places like my State of Iowa. We know
740 that is going to happen. You don't need a Ph.D. to figure
741 that out.

742 The competitive bidding program has been plagued with
743 problems from the beginning. Even proponents of the program
744 readily admit that the implementation process was
745 problematic. CMS delayed the bid window deadline several
746 times, provided bidding instructions while the bidding window
747 was open, sometimes provided unclear guidance to bidders,
748 operated an electronic document system that failed
749 frequently, and didn't notify suppliers that their bid
750 information was incomplete. Put frankly, this program has a
751 poor track record.

752 Now we have evidence of the devastating impact on
753 beneficiaries like my constituents who depend on medical

754 supplies, especially in rural areas. A recent study by Dr.
755 Kenneth Brown, a professor of economics at the University of
756 Northern Iowa, concluded that the competitive bidding program
757 for DME will have a significant negative impact on rural
758 areas, which are specifically excluded from the bidding
759 process. Dr. Brown reached this conclusion based on a study
760 of the current state of the industry, the financial results
761 across the industry and the 32 percent average reduction in
762 reimbursements that is resulting from round one bids.
763 Specifically, Dr. Brown believes that my home State of Iowa
764 will lose 40 to 50 percent of its DME suppliers in the
765 aftermath of competitive bidding. That is unacceptable to me
766 and the people I represent.

767 Now, despite the data and track record, CMS has moved
768 forward again on its round one re-bid and the problems are
769 surfacing again. In addition to questions about the impact
770 in rural areas, other questions have arisen about the level
771 of transparency in the process so far, and this is a
772 bipartisan issue that almost 150 of my colleagues have raised
773 concerns about. I would hope that CMS would go above and
774 beyond to provide full and open transparency into the bidding
775 process, which has been a high priority of the President.
776 Unfortunately, the vital information is unavailable for both
777 Congress and the program advisory and oversight committee

778 about how those rates have been determined, access to care
779 for beneficiaries and the impact on small providers.

780 For all of those reasons, Mr. Chairman, I am glad you
781 decided to hold the hearing and I look forward to having many
782 of these questions finally getting the answer they deserve.

783 And last, I would like to request unanimous consent to
784 submit the following items to the record: Dr. Kenneth
785 Brown's study on the impact of competitive bidding in rural
786 areas, testimony by Jim Tozzi, a member of the board of
787 directors of the Center for Regulatory Effectiveness, and on
788 behalf of Representative Jay Inslee, a letter from Care
789 Medical and Rehabilitation in Seattle, Washington.

790 Mr. {Pallone.} Without objection, so ordered.

791 [The information follows:]

792 ***** COMMITTEE INSERT *****

|

793 Mr. {Braley.} Thank you, Mr. Chairman.

794 [The prepared statement of Mr. Braley follows:]

795 ***** COMMITTEE INSERT *****

|
796 Mr. {Pallone.} Thank you, Mr. Braley.

797 Next is the gentlewoman from Ohio, Ms. Sutton.

798 Ms. {Sutton.} Thank you, Mr. Chairman, for holding this
799 very important hearing today.

800 This hearing is not only about access to the health care
801 for the American people but it is also about jobs and it is
802 about our economy. It is about our seniors, veterans and
803 other patients and their ability to access wheelchairs and
804 oxygen tanks and other durable medical equipment. This
805 equipment is often essential for their survival. Many of
806 these patients in need are covered by Medicare, Medicaid and
807 TRICARE, and this process will make a difference in whether
808 they will continue to have access to the equipment they need
809 and the help that they need.

810 Today we are here to review the current durable medical
811 equipment bidding process and determine whether it works for
812 and with our patients and for our small businesses. While
813 restructuring the durable medical equipment bid program is
814 necessary to prevent the waste, fraud and abuse in the
815 system, it must not be done at the expense of losing
816 thousands of jobs and preventing patients from accessing what
817 they need.

818 For manufacturers and suppliers, the transition to the

819 so-called competitive bidding program has been complex and
820 time consuming, and the irony of it all is it is not
821 competitive. Knowing as much information as possible is
822 crucial to submitting bids. CMS's plan to overhaul the
823 system is well intended but must be done carefully and
824 sensibly. Initial attempts by CMS to implement the first
825 round of competitive bidding were seriously flawed, and as a
826 result the requirement to resubmit all round one bids has
827 delayed the entire program by 2 years but CMS is already
828 preparing for round two. If this is truly being done in the
829 spirit of transparency and before we move to round two, we
830 need to know who are the recipients of round one bids. CMS
831 has failed to identify them, even after 136 Members of
832 Congress formally asked for the information. Thirteen of
833 those members are from Ohio.

834 The process must be immediately reviewed and changed.
835 In my district alone, thousands of jobs are at stake, and in
836 the State of Ohio thousands more are at stake. So let us be
837 clear. Our country needs to continue making things here. We
838 must not create a new bidding process that is less
839 transparent and encourages American businesses to move
840 overseas. We want to encourage businesses to keep making
841 their products right here and right in Ohio where I am so
842 proud to represent. And at the end of the day, if we don't

843 fix this process, our manufacturers will suffer, our
844 employees will suffer and our patients will suffer. It
845 doesn't have to be that way but it is critically important
846 that we get it right.

847 I thank you for having the hearing, and I yield back the
848 balance of my time.

849 [The prepared statement of Ms. Sutton follows:]

850 ***** COMMITTEE INSERT *****

|
851 Mr. {Pallone.} Thank you.

852 Next is the gentlewoman from California, Ms. Eshoo.

853 Ms. {Eshoo.} Thank you, Mr. Chairman. I along with all
854 the members of the subcommittee thank you for holding this
855 important hearing on Medicare's competitive bidding program
856 for durable medical equipment. It is important for the
857 committee to examine the status of this program which for
858 years has seen the mismanagement and the fraud that has been
859 a part of it. This is all carried by Medicare. Anyone that
860 cares about Medicare and its solvency as well as seniors owe
861 something to the examination and that is what we are doing
862 today.

863 We all know that durable medical equipment covers
864 products that range from wheelchairs, oxygen concentrators,
865 hospital beds, walkers and diabetic testing supplies. These
866 are all essential health care products and beneficiaries are
867 responsible for paying the other 20 percent in addition to
868 any unpaid deductible. I am familiar with every single one
869 of these products with the exception of the diabetic testing
870 supplies. I had to get them for either my mother or my
871 father or for both, so I am very familiar with who I went to,
872 who delivered, what they cost, what the rental costs were,
873 all of that, because I was in charge of their care.

874 There is inflated costs that hurt seniors directly and
875 not just the Medicare system as a whole. We place value on
876 the importance of comprehensive quality care for the elderly
877 in our country and the rates of fraud and abuse that the GAO
878 has uncovered, in my view, are sickening.

879 I just want to give some examples. In 2006, the HHS
880 Office of the IG reported that Medicare would allow \$7,215 in
881 payments over 36 months to oxygen suppliers for oxygen
882 concentrators that cost \$587 on average to purchase. In
883 2009, the OIG reported that in 2007 Medicare allowed \$4,018
884 for standard power wheelchairs that cost suppliers \$1,048 to
885 acquire. Anyone that stays up late at night sees these
886 advertisements for wheelchairs and that they will guarantee
887 that Medicare picks up the entire tab for it. So I am not
888 against Medicare making payments for these things, but you
889 know what? I think we all need to recognize that something
890 is not right in this.

891 So this examination today is a very important one. I
892 think the early indicators are positive that the new
893 competitive bidding process is working. I understand that
894 suppliers don't like it, but this is a new day. We have the
895 responsibility to extend the life of the trust fund of
896 Medicare. I have heard an unending chorus relative to the
897 new health law and saying all kinds of things about Medicare.

898 This is an area where like it or not, we have to find ways to
899 save money, find new ways to do the old things in a better
900 way and save money and still take good care of people. We
901 have had a system where people are used to it, made a lot of
902 money on it. I think that there has been documented abuse of
903 that system.

904 So I hope what we learn today is, what is working, what
905 isn't and what we can improve upon as we move forward. But I
906 think central to this really must be the cost to Medicare and
907 the cost to seniors. Medicare doesn't pick up the whole tab
908 for this, but as one member I am convinced that we can do
909 this in a much better way and save money. I think that is
910 already documented by the IG.

911 So thank you for having this hearing, Mr. Chairman, and
912 look forward to the discussion and the debate.

913 [The prepared statement of Ms. Eshoo follows:]

914 ***** COMMITTEE INSERT *****

|
915 Mr. {Pallone.} Thank you, Ms. Eshoo.

916 And last, I believe, is the gentlewoman from Florida,
917 Ms. Castor.

918 Ms. {Castor.} Good morning, Mr. Chairman, and thank you
919 very much for convening this hearing today.

920 The durable medical equipment competitive bidding
921 program is of great concern to both patients and suppliers in
922 my home State of Florida, so I am pleased today that we are
923 going to take a closer look at what is happening.

924 Florida is among the areas most affected by the DME
925 bidding program. In my Tampa Bay area community, the
926 greatest concerns about the bidding program deal with
927 fairness. Longstanding local suppliers now find themselves
928 in trouble because they are losing bids to larger companies
929 outside of the community and often out of state. According
930 to the Florida Alliance of Home Care Services, out-of-area
931 companies without experience bid at prices that are far below
932 the cost of local services and then later walk away from
933 their bids, causing great turmoil.

934 Other concerns surround the program's efficacy in
935 actually targeting fraud in the right way. There are claims
936 that some of the companies that have been awarded bids are
937 under fraud investigation or have settled fraudulent claims

938 with a large payout, and in Florida where the MEDPAC has
939 identified, and we all know it, huge geographic disparities
940 in Medicare spending, especially in DME in certain parts of
941 Florida, we have got to make sure that if we are targeting
942 fraud we are doing it in the right way.

943 Competitive bidding can be great, as my colleague said
944 from Iowa. It sounds great. But we have got to make it
945 work. It can't just be totally arbitrary. If we are going
946 to have competitive bids, is it right that companies that
947 have been involved in fraud before Medicare are taking some
948 of these bids away from our local suppliers that have a
949 proven history.

950 Today's hearing is critical to really getting to the
951 bottom of these issues and let us get a better understanding.

952 So at this time, Mr. Chairman, I would like to ask
953 unanimous consent that the committee receive for the record a
954 statement of my colleague, Ron Klein from Florida, regarding
955 the topic of concern today.

956 Mr. {Pallone.} Thank you, Ms. Castor.

957 Ms. {Castor.} I ask unanimous consent.

958 Mr. {Pallone.} Absolutely. Without objection, so
959 ordered.

960 [The information follows:]

961 ***** COMMITTEE INSERT *****

|

962 Ms. {Castor.} Yield back.

963 [The prepared statement of Ms. Castor follows:]

964 ***** COMMITTEE INSERT *****

|
965 Mr. {Pallone.} And if any other member wants to submit
966 a statement for the record, we will obviously have no problem
967 with that, if any other member wishes to do so.

968 Now, that ends our opening statements by members of the
969 subcommittee so I would ask our first panel to come forward
970 at this time, if you would. Let me welcome all of you and
971 introduce each of you. On the first panel, beginning on my
972 left, we have Mr. Laurence Wilson, who is Director, Chronic
973 Care Policy Group of the Center for Medicare and Medicaid
974 Services with U.S. Department of Health and Human Services.
975 Next we have the Hon. Daniel Levinson, who is Inspector
976 General from the Office of the Inspector General again with
977 the Department of Health and Human Services. And lastly is
978 Ms. Kathleen King, who is Director of Health Care for the
979 U.S. Government Accountability Office.

980 I think you, we try to keep the opening statements to 5
981 minutes and then those statements become part of the record,
982 and of course, if you want to submit additional brief or
983 pertinent statements in writing for inclusion in the record,
984 you may do so. And so I will start with Mr. Wilson.

|
985 ^STATEMENTS OF LAURENCE WILSON, DIRECTOR, CHRONIC CARE POLICY
986 GROUP, CENTER FOR MEDICARE AND MEDICAID SERVICES, U.S.
987 DEPARTMENT OF HEALTH AND HUMAN SERVICES; HON. DANIEL
988 LEVINSON, INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL,
989 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KATHLEEN
990 KING, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY
991 OFFICE

|
992 ^STATEMENT OF LAURENCE WILSON

993 } Mr. {Wilson.} Good afternoon, Chairman Pallone, Ranking
994 Member Whitfield and distinguished members of the
995 subcommittee. I am pleased to be here today to discuss the
996 durable medical equipment, prosthetics, orthotic supplies
997 competitive bidding program. This important initiative
998 required under the Medicare Modernization Act of 2003 and
999 recently expanded under the Affordable Care Act will reduce
1000 beneficiary out-of-pocket costs, improve the accuracy of
1001 Medicare's payments, help combat fraud and ensure beneficiary
1002 access to high-quality items and services.

1003 CMS initially implemented the program on July 1, 2008,
1004 in 10 metropolitan areas. After 2 weeks of operation, the
1005 program was delayed by the Medicare Improvements for Patients

1006 and Providers Act. CMS has examined the program closely
1007 including lessons learned from the initial round of bidding
1008 in 2008. We have made the changes required by law and many
1009 other significant improvements and are prepared to implement
1010 the re-bid of the program on January 1, 2011. We will do so
1011 in a way that ensures a smooth transition for beneficiaries
1012 and suppliers while providing effective oversight and
1013 monitoring.

1014 CMS had worked closely with stakeholders including its
1015 external advisory committee to design and implement the
1016 competitive bidding program in a way that is fair for
1017 suppliers and sensitive to the care needs of beneficiaries.
1018 For example, the program includes provisions to promote small
1019 supplier participation and numerous protections for
1020 beneficiaries. As designed, the program results in a large
1021 number of winners so that beneficiaries have a choice and
1022 there will continue to be competition among contract
1023 suppliers on the basis of customer service and quality.

1024 In addition, quality standards and accreditation
1025 combined with financial standards provides safeguards to
1026 support good quality and customer service while acting to
1027 weed out illegitimate suppliers and ensure a level playing
1028 field for suppliers competing under the program.

1029 CMS made a number of important improvements to the

1030 program in preparation for the re-bid in nine areas of the
1031 country. These changes provide for a fair process and more
1032 effective scrutiny of suppliers' qualifications and the
1033 integrity of their bids. For example, CMS initiated a
1034 comprehensive bidder education campaign much earlier in the
1035 process. CMS developed a more user-friendly online bidding
1036 system, which did not experience the glitches that troubled
1037 bidders in 2007. MIPPA mandated a process to alert bidding
1038 suppliers if they were missing certain financial bid
1039 documents. This was very effective with three-quarters of
1040 suppliers taking advantage of the process. CMS verified
1041 bidders' compliance with all state licensure requirements
1042 early in the bid evaluation process and CMS improved its
1043 process for evaluating bids to ensure they reflect a bona
1044 fide amount that a provider can provide an item for.

1045 CMS also carefully reviewed the capacity of each
1046 supplier to provide services. New suppliers and those that
1047 told us they could greatly expand their businesses received
1048 higher scrutiny. These and other changes helped ensure that
1049 payment amounts are based on realistic bids and that there
1050 would be more than enough qualified suppliers to serve
1051 patients. These process improvements also tend to favor
1052 local experienced suppliers. For example, 73 percent of
1053 contract offers made on July 1 went to suppliers with a

1054 history of providing the specific product in the local area.

1055 A full 95 percent of offers went to experienced suppliers.

1056 Our experience with the round one re-bid has also shown

1057 that competitive bidding has the potential to bring value to

1058 Medicare beneficiaries and taxpayers compared to the current

1059 fee schedule. In fact, average savings across the nine

1060 metropolitan areas is 32 percent. This translates into \$17

1061 billion in savings to Medicare over 10 years and another \$11

1062 billion in savings for beneficiaries through lower

1063 coinsurance and premium reductions. As a specific example in

1064 my Miami, the price of a standard power wheelchair will drop

1065 \$1,274.

1066 In the coming weeks, we will complete the contracting

1067 process and publish the names of the new contract suppliers.

1068 At the same time, we will ramp up our outreach and education

1069 efforts focusing in beneficiaries, referral agents, suppliers

1070 and others. As with any new program, we recognize this is a

1071 change for suppliers and patients. We will monitor

1072 implementation closely and are prepared to act swiftly to

1073 address any concerns that may arise on behalf of

1074 beneficiaries and suppliers. We have a network in place

1075 built around our national competitive acquisition ombudsman,

1076 local ombudsmen, regional office CMS caseworkers, contractors

1077 and Medicare call centers to address and track questions and

1078 concerns. We will also survey beneficiaries and perform
1079 active claims surveillance aimed at ensuring Medicare
1080 beneficiaries are receiving quality care.

1081 In summary, we will be diligent and thoughtful in our
1082 implementation of the program and continue to work closely
1083 with our stakeholders. Again, I appreciate the invitation
1084 this morning to testify before you and would be happy to take
1085 any questions. Thank you.

1086 [The prepared statement of Mr. Wilson follows:]

1087 ***** INSERT 1 *****

|

1088 Mr. {Pallone.} Thank you, Mr. Wilson.

1089 Mr. Levinson.

|
1090 ^STATEMENT OF DANIEL LEVINSON

1091 } Mr. {Levinson.} Good afternoon, Chairman Pallone, Mr.
1092 Whitfield and members of the subcommittee. Thank you for the
1093 opportunity to discuss the integrity of Medicare's coverage
1094 of durable medical equipment and supplies, or DME.

1095 Medicare pays for DME on behalf of more than 11 million
1096 beneficiaries at a cost of more than \$10 billion a year. In
1097 2009, CMS estimated that more than half of DME claims were
1098 paid in error.

1099 The vast majority of Medicare suppliers are honest and
1100 well intentioned. However, even a small minority of
1101 unscrupulous suppliers drains Medicare funds and puts
1102 beneficiaries at risk. OIG's work has demonstrated that this
1103 benefit is particularly vulnerable to fraud, waste and abuse.
1104 My testimony focuses on two key vulnerabilities described
1105 more fully in my written statement. These are the ease with
1106 which fraudulent suppliers obtain billing privileges and DME
1107 payment rates that exceed market prices.

1108 Although DME accounts for just 2 percent of Medicare
1109 spending, approximately 14 percent of OIG's health care fraud
1110 investigations involve DME. These investigations have found
1111 that criminals set up sham DME storefronts and fraudulently

1112 bill Medicare for millions of dollars. Then they close up
1113 shop and reopen in a new location under a new name and repeat
1114 the fraud. Entry into the DME business has been too easy,
1115 and oversight and enforcement of Medicare enrollment
1116 standards has been weak. For example, almost one-third of
1117 the 1,600 DME suppliers billing Medicare in south Florida did
1118 not have an open and staffed physical location when OIG
1119 conducted site visits.

1120 In addition, Medicaid frequently reimburses for DME
1121 federal rate above acquisition costs resulting in waste and
1122 increased beneficiary copayments and making fraudulent
1123 billing more lucrative. For example, in 2007, OIG found that
1124 Medicare reimbursed suppliers for wound therapy pumps based
1125 on a purchase price of more than \$17,000. However, suppliers
1126 paid approximately \$3,600 for new models of these pumps.
1127 Likewise, in 2007 Medicare paid about \$4,000 for standards
1128 power wheelchairs that cost suppliers about \$1,000 to
1129 acquire. Our investigations have demonstrated that pricing
1130 disparities make DME a lucrative target for criminals. In
1131 numerous cases, criminals have supplied unneeded power
1132 wheelchairs and scooters to beneficiaries because the
1133 Medicare payment is excessive enough to make this scam
1134 profitable.

1135 The profitability of DME fraud has given rise to

1136 increasingly sophisticated schemes and more violent
1137 perpetrators. For example, in southern California, an
1138 individual established numerous sham DME companies using
1139 street gang members to pose as owners. These sham suppliers
1140 enrolled in Medicare and submitted millions of dollars in
1141 fraudulent claims for power wheelchairs and orthotic devices.
1142 The gang members involved had previously been convicted of
1143 charges ranging from assault to narcotics violations.

1144 In response, we are taking strong action to protect the
1145 integrity of the Medicare DME benefit. Innovative uses of
1146 information technology and data analysis have dramatically
1147 enhanced the government's ability to detect, prevent and
1148 respond to fraud. OIG analyses data to identify fraud
1149 hotspots and to alert CMS to potential fraud so that it can
1150 implement appropriate program safeguards.

1151 OIG and the Department of Justice are accelerating the
1152 government's response to fraud schemes. Medicare fraud
1153 Strike Force can quickly detect, investigate and prosecute
1154 fraud before the criminals and stolen funds disappear. The
1155 Strike Force teams combine data analysis with field
1156 intelligence to crack down on sham DME suppliers and other
1157 fraud perpetrators. Our teams are working to stay ahead of
1158 the criminals as their fraud schemes replicate and migrate.

1159 CMS has taken some important steps such as requiring

1160 accreditation and surety bonds to strengthen provider
1161 enrollment standards. The Affordable Care Act requires CMS
1162 to conduct more stringent risk-based provider enrollment
1163 screening.

1164 The Medicare competitive bidding program holds promise
1165 to address payment vulnerabilities by better aligning DME
1166 reimbursement with market prices. It also provides a
1167 mechanism for ensuring that CMS has better information about
1168 suppliers when granting billing privileges. If policymakers
1169 consider a different course, it remains imperative to take
1170 prompt, appropriate action to ensure the integrity of the
1171 benefit. My office remains committed to monitoring program
1172 integrity and beneficiary access to reasonably priced,
1173 medically necessary, quality medical equipment and supplies.

1174 In conclusion, I appreciate and share your commitment to
1175 fighting DME fraud, waste and abuse and I welcome your
1176 questions.

1177 [The prepared statement of Mr. Levinson follows:]

1178 ***** INSERT 2 *****

|
1179 Mr. {Pallone.} Thank you, Mr. Levinson.
1180 Ms. King.

|
1181 ^STATEMENT OF KATHLEEN KING

1182 } Ms. {King.} Mr. Chairman and members of the
1183 subcommittee, I am pleased to be here today to discuss
1184 Medicare's competitive bidding program for DME.

1185 Medicare's DME program for competitive bidding was
1186 implemented in part to save Medicare money. Both we and the
1187 Office of the HHS Inspector General have reported that
1188 Medicare and its beneficiaries have paid higher than market
1189 prices for various medical equipment and supplies. These
1190 overpayments increase cost to both Medicare and its
1191 beneficiaries.

1192 Today I am going to focus on three problem areas we
1193 identified in our November 2009 report and how CMS is
1194 addressing those problems. These three areas are: providing
1195 suppliers with bid submission information, the electronic
1196 bidding submission system and the bid disqualification
1197 notification process.

1198 First, in the bidding process for round one, we found
1199 several problems regarding the timeliness of information
1200 provided by CMS and lack of clarity in bid submission
1201 information provided to bidders. We also found that CMS was
1202 not able to inform suppliers what required financial

1203 documentation was missing or incomplete. In contract, for
1204 the round one re-bid, CMS provided information earlier to
1205 suppliers, took several steps to make its financial
1206 documentation instructions clear and notified suppliers when
1207 their financial documentation was incomplete.

1208 In response to concerns expressed during round one that
1209 winning suppliers did not have the necessary capacity to
1210 fulfill their contracts, for the re-bid CMS developed a
1211 systematic method for reviewing suppliers' capacity and
1212 expansion plans. To address concerns that some suppliers
1213 were awarded contracts in round one in States for which they
1214 were not licensed, CMS clarified the requirement that
1215 suppliers be licensed in all States for which they submitted
1216 bids and provided directories to assist suppliers in
1217 identifying state licensing requirements.

1218 Secondly, with regard to the electronic bid submissions,
1219 we found that the bid submission system had several
1220 operational problems that affected suppliers' ability to
1221 submit their bids. For the re-bid, CMS developed a new
1222 electronic bid submission system, DBidS, which was designed
1223 to be user friendly, easier for suppliers to navigate and
1224 capable of providing detailed bidding instructions in user-
1225 friendly language. DBidS also has status indicators to show
1226 whether the bidding forms are complete and links to direct

1227 bidders to incomplete data.

1228 For the third issue, the bid disqualification process,
1229 in the first round almost half of the bids were disqualified.
1230 CMS conducted a post-bidding review process through which the
1231 agency reversed some of these decisions. However, CMS did
1232 not effectively notify suppliers about the opportunity for
1233 this post-bidding review process. To improve future rounds,
1234 we recommended that if CMS decides to conduct a review of
1235 disqualification decisions made during round one, they should
1236 notify all suppliers of that process, give suppliers and
1237 equal opportunity for review and clearly indicate how they
1238 can request a review. CMS agreed with our recommendations.

1239 Beginning in July 2010, CMS sent notification letters to
1240 winning suppliers offering them contracts but did not notify
1241 the losing suppliers. CMS informed us after the round one
1242 re-bid contracting process is complete, they will send
1243 letters to disqualified suppliers explaining why they were
1244 disqualified. CMS said the letters will also explain the
1245 process through which suppliers may ask questions and express
1246 concerns, and they said if they find that in the course of
1247 responding to these concerns they determine that an error has
1248 been made, it is possible that a contract would be offered to
1249 a supplier.

1250 We plan to do further work regarding the round one re-

1251 bid. As required by MIPPA, we will examine the program's
1252 impact on Medicare beneficiary access to items and services
1253 and on small suppliers, among other topics. Our study is to
1254 be completed a year after payments on the first round are
1255 made.

1256 Mr. Chairman, this concludes my prepared statement. I
1257 would be happy to answer any questions. Thank you.

1258 [The prepared statement of Ms. King follows:]

1259 ***** INSERT 3 *****

|
1260 Mr. {Pallone.} Thank you, Ms. King, and now we will
1261 start and ask questions from the members. It is generally 5
1262 minutes for each of us, and I will start with myself.

1263 My questions are to you, Mr. Wilson. You probably heard
1264 before, many suppliers have expressed the belief that winning
1265 suppliers will be unable to meet their contract performance
1266 requirements, in effect, you know, it happens a lot now with
1267 the economy that they offer up a suicide bid just to stay in
1268 the program without any actual ability to deliver on their
1269 promises or maybe they think they can deliver but they can't
1270 ultimately. Have you seen examines of what I call suicide
1271 bidding and do you have any protections in place to guard
1272 against inappropriate bids?

1273 Mr. {Wilson.} Mr. Chairman, I don't know that I have
1274 seen an example of a suicide bid. We have a process in place
1275 to determine whether or not suppliers are qualified,
1276 licensed, accredited, meet all the standards required by
1277 Medicare. The second part of the process deals with whether
1278 or not their bids are bona fide, and yes, we have found bids
1279 that aren't bona fide. We do have a process where we
1280 analyze, request information such as invoices from suppliers
1281 to show, to prove and document that they can meet a certain
1282 price and we requested that information and verified whether

1283 or not there were what we would term a low-ball bid,
1284 unsustainable bid.

1285 Mr. {Pallone.} I know you said you have a plan, but as
1286 another follow-up, will referral agents, and I guess, you
1287 know, would there be any kind of follow-up where people will
1288 be able to report problems and, you know, you find out about
1289 those problems as opposed to just looking at the plans?

1290 Mr. {Wilson.} Well, I think that is a very important
1291 part of the program. I think the key here for us is ensuring
1292 that we have enough qualified, able suppliers in place to
1293 provide quality services to our beneficiaries. That is the
1294 key to the entire program. Our ability to educate,
1295 communicate with folks that are involved in that process like
1296 referral agents including physicians, hospitals--

1297 Mr. {Pallone.} Social workers?

1298 Mr. {Wilson.} Social workers, State health insurance
1299 programs. That is all part of our communications plan that
1300 we will ramp up. We have already started but we will ramp up
1301 towards the end of this month when we release the list of
1302 contract suppliers. It is a very key part of the program.
1303 To the extent that either a supplier or a beneficiary has a
1304 concern, we will be educating all of these entities on where
1305 they go through direct mail, through documents, websites,
1306 again talking with partner organizations that deal with

1307 beneficiaries so that a beneficiary will know to call 1-800.
1308 A complaint would get routed. We would track that complaint.
1309 We have an ombudsman program that can deal with that
1310 complaint. We have local ombudsman that can--

1311 Mr. {Pallone.} And what if there is a shortage, I mean,
1312 if there a problem? Do you have the ability to add capacity
1313 if shortages arise, you know, like if a contractor fails?

1314 Mr. {Wilson.} We believe we have offered contracts to
1315 more than enough suppliers to provide access to beneficiaries
1316 in these nine areas. A core principle in the program with
1317 respect to offering contracts is to set a demand target that
1318 is very, very high so that we can guarantee we have enough
1319 suppliers. So if a supplier has a problem, maybe we lose
1320 one, maybe their number gets revoked, we will still have
1321 enough suppliers. If we need to add a supplier, we can
1322 certainly go out and offer a contract.

1323 Mr. {Pallone.} Okay. My second question is more local,
1324 you know, referring to my State. In the Medicare Improvement
1325 for Patients and Providers Act of 2008, it gave CMS the
1326 authority to split metropolitan statistical areas more than 8
1327 million people into separate bidding areas. Now, New Jersey
1328 is in one of these very large metropolitan areas that
1329 includes New York City, northern New Jersey, Long Island,
1330 Pennsylvania, you know, like maybe 20 million people

1331 altogether. I think because the geographic area and the
1332 number of people is so large, it is essential that the MSA be
1333 divided into market areas that better reflect prevailing
1334 medical practice, and it is my understanding that CMS has
1335 proposed to subdivide this market into five smaller
1336 competitive bidding areas. Is that correct, and isn't it
1337 true that these smaller areas--well, I want to know is it
1338 true, and secondly, if these smaller areas are going to
1339 better reflect the differences between southern New Jersey,
1340 northern New Jersey, New York. Do you want to respond to
1341 that?

1342 Mr. {Wilson.} Sure. It is absolutely true, Mr.
1343 Chairman. We did discuss that issue with our advisory
1344 committee. We received advice. We put our proposal in a
1345 proposed rule this spring and have received comments and are
1346 looking at the issue right now.

1347 Mr. {Pallone.} So you have made a decision to subdivide
1348 the market?

1349 Mr. {Wilson.} We have proposed a methodology in a rule
1350 to subdivide the market, and we do believe that is the
1351 correct thing to do here.

1352 Mr. {Pallone.} And how is that being done to reflect
1353 the differences, you know, as I said, New Jersey versus New
1354 York, north, south Jersey, whatever?

1355 Mr. {Wilson.} Right. Well, the issue that we are
1356 dealing with is really the New York metropolitan area so we
1357 are looking at New Jersey counties that are west of the city
1358 as one area and New Jersey counties that are immediately
1359 south of the city as another area. We also added in Pike
1360 County, Pennsylvania, to the western New Jersey counties. I
1361 don't think people like that so we will be looking at that
1362 aspect of our proposal very closely but we certainly did look
1363 at these market areas trying to develop more homogeneous
1364 market areas that would better serve suppliers' ability to
1365 deal with patients across a smaller area.

1366 Mr. {Pallone.} I don't want to take up any more time
1367 but I may follow up with some written questions to you about
1368 that.

1369 Mr. {Wilson.} Absolutely.

1370 Mr. {Pallone.} Thank you.

1371 Mr. Whitfield.

1372 Mr. {Whitfield.} Thank you. Mr. Chairman, I would like
1373 to ask unanimous consent that we enter into the record this
1374 testimony from a representative of ConvaTec, a company on
1375 this issue.

1376 Mr. {Pallone.} Without objection, so ordered.

1377 [The information follows:]

1378 ***** COMMITTEE INSERT *****

|
1379 Mr. {Whitfield.} Mr. Burgess is so fast, I didn't know
1380 he had already done it.

1381 Mr. {Pallone.} You have got to watch him.

1382 Mr. {Whitfield.} Thank you for your testimony. We
1383 appreciate it very much.

1384 Mr. Wilson, let me just ask you, critics of this program
1385 have noted that the first effort needed to be terminated, the
1386 first bid effort needed to be terminated in 2008. Would you
1387 please explain specifically why that was necessary and why
1388 CMS believes that the second round will be different?

1389 Mr. {Wilson.} Well, I can certainly talk to some of the
1390 issues and concerns from the 2008 round of bidding that I
1391 think we have tried to address and I believe that we have
1392 addressed consistently with the GAO's testimony today, but
1393 there were a number of concerns, particularly with regard to
1394 how the agency communicated information about bidding, the
1395 timing of communication that perhaps contributed to confusion
1396 about what the rules were. That is something that we have
1397 acted to fix in this round. We didn't revise instructions
1398 midway through the bidding process this time, as we did last
1399 time. I think that was very important to provide a level
1400 playing field for all suppliers involved in the bidding. The
1401 online bidding system last time, as I mentioned in my

1402 testimony, did not work. It was frustrating. Suppliers
1403 would enter information, think they saved it, and when they
1404 went back it was gone. There is a lot of information
1405 associated with the bids and we recognize that was a
1406 frustrating process. We fixed that. We did not have those
1407 problems this time. Those were legitimate concerns that
1408 needed to be addressed. We did not validate licensing up
1409 front in the process in 2008 so we looked to verify licenses
1410 afterwards, after the bids were submitted. What that may
1411 have led to is speculative bids being submitted by certain
1412 suppliers that maybe came in from out of state. This time we
1413 said you need to have your licenses up front. They have to
1414 be in order and all of your other qualifications in line such
1415 as accreditation so that that tended to favor local suppliers
1416 since they really just needed to have--local suppliers tended
1417 to be the ones that had local licenses and so those were the
1418 ones that I think benefited from that policy.

1419 I think the scrutiny that we placed on bids this time
1420 was more, that we heard a lot of concerns about, one, whether
1421 they would be too many low-ball bids coming into the process.
1422 Again, we looked at that very closely, revised our process
1423 this time. We requested more information in terms of an
1424 explanation of suppliers' bids where we found them to be
1425 aberrantly low. We looked very closely at some of the

1426 invoices that were provided, and when a supplier could not
1427 justify the level of their bid if it was low, we would
1428 discard that bid.

1429 Mr. {Whitfield.} Let me--I appreciate your responding.
1430 You did a very good job of covering some areas but let me ask
1431 you another question here. I was reading an article recently
1432 about a provider in Tennessee that on this most recent round
1433 submitted a bid for all areas in the wheelchair category, and
1434 only about 10 percent of his business was really related to
1435 these wheelchairs, and he evidently was offered--he won the
1436 bid in basically half of those 10 areas, and he deliberately
1437 submitted a low bid according to the article I read, and when
1438 you all offered him the contract he refused the contract.
1439 Are you aware of that particular situation?

1440 Mr. {Wilson.} Yes, Congressman, I am aware of that
1441 situation. I have looked into it. At the outset I would say
1442 I can't talk about specific information in that supplier's
1443 bid. We consider bid information proprietary. I will say
1444 that everything in that article is not accurate.

1445 The other thing that I would say is, looking at the
1446 article the supplier was very clear that he felt his bid was
1447 a fair price compared to the quote, unquote, cost of goods.
1448 In fact, that leaves a higher gross margin and a lot less
1449 labor than your average complex rehab chair. So he thought

1450 he had a profit in there and that that was a good bid.

1451 Mr. {Whitfield.} Even though he--

1452 Mr. {Wilson.} Even though he refused it. The other
1453 thing that he said is that the primary reason he didn't
1454 accept it was because that particularly after round two
1455 utilization will drop substantially. Marketing and
1456 advertising drives utilization, it drives demand in
1457 reimbursement. It isn't going to allow for \$800 to \$1,000
1458 per chair for marketing and advertising anymore.

1459 Mr. {Whitfield.} But I think the concern is that you
1460 have someone like this that is really not in that business
1461 and he does a low-bid and then in the matrix as they look
1462 at final bid prices, it does put at a disadvantage a lot of
1463 the local suppliers. At least there is the concern for that,
1464 which may be valid or may not be valid. But my time is
1465 expired, so thank you.

1466 Mr. {Pallone.} Thank you.

1467 Chairman Dingell.

1468 Mr. {Dingell.} Mr. Chairman, thank you for your
1469 courtesy.

1470 Ms. King, you allude to a situation in your testimony
1471 where I am concerned. Would you say the DME program as
1472 currently constituted is unusually conducive to fraud as
1473 compared to the rest of Medicare? Yes or no.

1474 Ms. {King.} Yes.

1475 Mr. {Dingell.} Why do you feel that way?

1476 Ms. {King.} Congressman Dingell, I think there are
1477 several reasons for that. There are some parts of Medicare
1478 including DME where the barriers to entry have been
1479 historically low so that it doesn't take a lot to get into
1480 the market and it has made it easier for unscrupulous
1481 providers to enter into the market, to start billing
1482 Medicare, and then when people start to catch up to them to
1483 close up shove and move on to somewhere else.

1484 Mr. {Dingell.} Thank you. Please submit for the record
1485 what additional steps must be taken to see to it that we have
1486 completed the addressing of the problem of fraud with regard
1487 to durable medical equipment.

1488 Now, Ms. King, I want to compliment you and GAO. You
1489 know the respect I have for your agency.

1490 Ms. {King.} Thank you.

1491 Mr. {Dingell.} CMS has instituted many new requirements
1492 outside of the DME competitive bidding program with more help
1493 combating waste, fraud and abuse will come as a result of
1494 health reform. But even apart from that, CMS argues that
1495 competitive bidding will reduce fraud. In your testimony,
1496 you note that competitive bidding has the potential to reduce
1497 Medicare expenditures by using market forces. Question: Do

1498 you think that it might also reduce fraud amongst DME
1499 suppliers as CMS claims, yes or no?

1500 Ms. {King.} Yes.

1501 Mr. {Dingell.} Now, OIG draws a connection between
1502 overpayments and fraud. Essentially they say honey draws
1503 flies. Do you agree that there is a link between
1504 overpayments and fraud?

1505 Ms. {King.} I don't think that we have done work
1506 directly on that point.

1507 Mr. {Dingell.} Now, these questions are for Mr. Wilson
1508 or Ms. King. Changes have been made since round one. You
1509 have indicated in your testimony there are many problems
1510 reported during the initial round of competitive bidding.
1511 GAO documented unclear bidding instructions, poorly
1512 performing bidding software and inadequate supplier education
1513 before commencement of the bidding. MIPPA mandated many
1514 changes in the program that have been adopted in round one
1515 re-bid including the requirement that CMS allow suppliers a
1516 chance to complete their financial documentation at a date
1517 certain for quality accreditation. Question: Has CMS made
1518 other changes to facilitate fair competition in the round one
1519 bid? Yes or no.

1520 Mr. {Wilson.} I will answer, Congressman Dingell. Yes,
1521 I believe we have.

1522 Mr. {Dingell.} Ms. King?

1523 Ms. {King.} We haven't seen the final results yet so I
1524 think that we will reserve judgment until we see that.

1525 Mr. {Dingell.} Would you review these questions and see
1526 whether they are being fair to the bidders, and please report
1527 to the committee for inclusion in the record?

1528 Ms. {King.} Yes, we will.

1529 Mr. {Dingell.} Now, one of the problems GAO documented
1530 was that many suppliers were disqualified due to incomplete
1531 financial documentation, a fact that they were often not
1532 aware of. Based on your experience with regard to the round
1533 one re-bid, do you believe that this problem of suppliers
1534 being disqualified in large numbers due to incomplete
1535 documentation has been fully addressed?

1536 Ms. {King.} We haven't seen the results yet but I do
1537 think that the new bidding system has the potential to really
1538 help with that because it signals supplies when documentation
1539 is not provided or is incomplete.

1540 Mr. {Dingell.} Mr. Wilson?

1541 Mr. {Wilson.} I believe in answer to your question,
1542 Congressman, that the answer is affirmative. I can provide--

1543 Mr. {Dingell.} Would you please each review that and
1544 tell me what of the questions of basic fairness have not been
1545 properly and fully addressed by CMS for submission in the

1546 record?

1547 Now, another issue raised during MIPPA was again one of
1548 fairness. It seemed unfair that because bid instructions
1549 were changing, early bidders had to spend extra time to make
1550 sure their bids were still appropriate, and it seemed unfair
1551 in the GAO report that some suppliers were given a chance to
1552 review all their disqualifications while others were not.
1553 First of all, one, Mr. Wilson, is that true?

1554 Mr. {Wilson.} It is true that bid instructions and
1555 additional information were released during the bid window in
1556 2007, and so yes, it would be true.

1557 Mr. {Dingell.} Okay. Has that been corrected?

1558 Mr. {Wilson.} It has been corrected.

1559 Mr. {Dingell.} Are you satisfied with that?

1560 Mr. {Wilson.} I am satisfied.

1561 Mr. {Dingell.} Ms. King, what are your responses to
1562 those questions?

1563 Ms. {King.} Yes, we do think it has been corrected.
1564 With regard to the disqualification process and the review
1565 process, that has not occurred yet with the round one re-bid
1566 so we don't know what the outcome will be yet.

1567 Mr. {Dingell.} Is there anything that has to be done to
1568 assure that the unfairnesses that we are discussing here have
1569 been properly addressed?

1570 Ms. {King.} CMS has told us that they intend to provide
1571 notice to all suppliers about the reasons why they were
1572 disqualified and give them an opportunity to express an
1573 opinion.

1574 Mr. {Dingell.} I think we are agreed that these matters
1575 must be conducted fairly. Would you submit to us for the
1576 record any matters which need to be addressed by CMS to
1577 assure fair bidding?

1578 Ms. {King.} Yes, sir.

1579 Mr. {Dingell.} Now, again--

1580 Mr. {Pallone.} Mr. Chairman, just to note, you are a
1581 minute and a half over.

1582 Mr. {Dingell.} I am sorry, sir?

1583 Mr. {Pallone.} Just to note, you are a minute and a
1584 half over. If you want, you can continue a little bit but--

1585 Mr. {Dingell.} I ask that I be permitted to submit
1586 those questions. Mr. Chairman, may I just ask this one
1587 important question to each of the witnesses?

1588 You have all seen H.R. 6095, the bill I have introduced.
1589 Would you please tell me whether or not you have any concerns
1590 about how that will adversely impact the cost to the
1591 government of the program we are discussing? You may submit
1592 that for the record.

1593 Mr. Chairman, I yield back the balance of my time, and I

1594 thank you for your courtesy to me.

1595 Mr. {Pallone.} Thank you, Chairman Dingell.

1596 Next is the gentleman from Pennsylvania, Mr. Pitts.

1597 Mr. {Pitts.} Thank you, Mr. Chairman.

1598 Mr. Wilson, you claim that the overall savings to
1599 Medicare and beneficiaries will total \$28 billion over the
1600 first 10 years without compromising quality or access. Can
1601 you explain why you are so confident quality and access will
1602 be maintained at current levels?

1603 Mr. {Wilson.} Well, we will have a program in place to
1604 ensure quality, provide oversight, communicate with
1605 beneficiaries, communicate with beneficiaries, communicate
1606 with others involved in their care. We will have complaint
1607 process if we have of concerns. We will have a process in
1608 place to act swiftly to address those concerns. There are
1609 certain underlying features of the program which address
1610 quality, requirements on suppliers in terms of accreditation
1611 and quality standards, other parts of supplier standards
1612 which apply and with the competitive bidding program comes a
1613 more focused oversight effort on the suppliers that are
1614 involved in the program and have contracts. So we believe we
1615 have the mechanisms in place, the infrastructure in place to
1616 deal with individual beneficiary issues and more systemic
1617 beneficiary issues.

1618 One thing that is different in the program from 2008 is,
1619 we will be doing active claims surveillance on the claims as
1620 they come in to be able to see who is providing the care, who
1621 is getting the care and whether or not there are any issues
1622 or concerns. We can look and see things like are there more
1623 emergency visits, are there longer hospitalizations, are
1624 there some of the kinds of quality problems that we might be
1625 concerned about. So we will be looking very closely and we
1626 will have a plan in place and the resources in place to deal
1627 with problems as they arise.

1628 Mr. {Pitts.} What beneficiary protections are contained
1629 in the program?

1630 Mr. {Wilson.} There are a number of important
1631 beneficiary protections. I think one of the key ones is
1632 something that was provided in the law. It is called
1633 grandfathering. So for many suppliers and many
1634 beneficiaries, the existing supplier, even if they don't win
1635 a contract, they can stay in the program. The last time in
1636 2008 we saw that over 90 percent of oxygen suppliers--and of
1637 course oxygen patients are the ones that we would be most
1638 concerned about in terms of any quality adverse outcomes. So
1639 we expect that there will be a lot of grandfathering. We
1640 have selected a number of suppliers to be contract suppliers
1641 so that beneficiaries will have choice. If they don't like

1642 care somewhere, they can go somewhere else. We have a safety
1643 net provision provided by Congress called the physician
1644 authorization provision. If the physician for the patient
1645 feels a specific brand or mode of treatment is required, that
1646 has to be provided under the program by a contract supplier.
1647 Anti-discrimination provisions--we require suppliers under
1648 the program to provide the same treatments, the same items
1649 and services, brands, models to their Medicare patients as
1650 they do for their private patients. We have other provisions
1651 which require transparency, so we will be publishing and
1652 updating quarterly all the brands and all the models that
1653 each contract supplier provides so that beneficiaries,
1654 caregivers, referral agents can look and see what types of
1655 products and brands they want and sort of vote with their
1656 feet and go to suppliers that provide what they need, and
1657 that also creates competition around the quality of the items
1658 and services provided. And then as I mentioned--

1659 Mr. {Pitts.} Go ahead.

1660 Mr. {Wilson.} And then as I mentioned, the oversight
1661 and monitoring efforts that we will have in place.

1662 Mr. {Pitts.} Now, your testimony speaks of protections
1663 for small suppliers. What are these protections and how were
1664 they created?

1665 Mr. {Wilson.} The law asks us to put in place a program

1666 that allows suppliers the opportunity to participate in the
1667 program. We feel like we have done a lot more than that. We
1668 worked with the Small Business Administration to put a place
1669 a definition of a small supplier, which is something less
1670 than the definition or a lower threshold than a small
1671 business because many suppliers are very small mom-and-pop
1672 entities. We built some policies around that definition. We
1673 actually have what we call a 30 percent target, really a set-
1674 aside where we make sure that in every auction, in every bid
1675 in an area for a product category we insert 30 percent of the
1676 suppliers meet that definition, and if they don't, we add
1677 small suppliers.

1678 We found that with respect to the current contract
1679 offers that we have made, we have exceeded that target. It
1680 is almost half, 48 or 49 percent are small suppliers that
1681 meet that definition. We allow small suppliers to band
1682 together as a network to meet all the requirements under the
1683 bidding program. Those are just a few of I think the most
1684 important provisions.

1685 Another key one I will mention is that we have the way
1686 the policy works, the way the bidding program is structured
1687 results in multiple suppliers so we try to select lots and
1688 lost of suppliers. Ninety-two oxygen supply contracts are
1689 offered in Miami. I think 42 wheelchair contracts offered in

1690 Riverside. We try to make sure there are lots of suppliers
1691 so that beneficiaries have choice, more suppliers can
1692 participate. That also has an upward effect on price.

1693 Mr. {Pitts.} My time is expired. Thank you, Mr.
1694 Chairman.

1695 Mr. {Pallone.} Thank you, Mr. Pitts.

1696 Next is the gentlewoman from Ohio, Ms. Sutton.

1697 Ms. {Sutton.} Thank you, Mr. Chairman.

1698 Mr. Wilson, would you agree with me that it is
1699 absolutely important to cut out waste, fraud and abuse and
1700 that we must do so through a fair process?

1701 Mr. {Wilson.} Absolutely.

1702 Ms. {Sutton.} One that will permit patients to continue
1703 to access appropriate and quality care and services?

1704 Mr. {Wilson.} I do.

1705 Ms. {Sutton.} Okay. Is CMS monitoring whether
1706 beneficiaries in the bid areas will be able to continue to
1707 access the same brand products and the level of services,
1708 particularly for beneficiaries with chronic conditions and
1709 needs?

1710 Mr. {Wilson.} We certainly will be collecting that
1711 information, asking suppliers to update it quarterly and
1712 publishing it.

1713 Ms. {Sutton.} Okay. Mr. Wilson, as you are going

1714 forward with the next bidding process--actually let me just
1715 direct this to anybody who has information. We have heard a
1716 lot, and we have heard some questions that reflect it. There
1717 are many reasons why bids are low but industry is saying that
1718 out of the area and inexperienced companies were allowed to
1719 bid and set area rates, then withdraw from the bid process
1720 with no repercussions, leaving the area and local providers
1721 to deal with unrealistic bids, and I guess the question would
1722 be, why would you allow out-of-area companies with no
1723 accountability to bid in the first round areas, and after
1724 they withdraw then keep those illegitimate bids in the matrix
1725 for crafting new bid rates, if that is indeed what happened?

1726 Mr. {Wilson.} Sure, I can provide some information I
1727 think to address this issue, Congresswoman. I think during
1728 the first round in 2008, 95 percent of contract offers were
1729 accepted. I think while we are not done the contracting
1730 process, we expect to see something similar so most contracts
1731 are being accepted. I think the other thing that I would say
1732 is that 72 percent of contract offers went to providers,
1733 local suppliers that provide the product category for which
1734 they bid. A further 11 percent were local suppliers that
1735 maybe provided a different product category but local
1736 suppliers and a further 12 percent for a total of 95 percent
1737 were maybe out-of-area suppliers but were experienced in that

1738 product category. So I think that we see is overall 95
1739 percent of the suppliers being experienced meeting all of our
1740 requirements. We have certainly never had requirements in
1741 Medicare that say a particular provider can't expand from one
1742 State to another State or one city to another city, and we
1743 didn't see an ability to place such restrictions on this
1744 program here.

1745 Ms. {Sutton.} Well, there are a lot of concerns and of
1746 course you have heard many of them expressed here today, and
1747 whether it is the small suppliers, I will say that it is my
1748 understanding that the Cleveland Clinic, for example, bid
1749 below the allowable price and didn't win one contract. In
1750 January they will no longer be able to provide services and
1751 patients will have to wait until the DME provider that won
1752 the bid will be able to provide it. So you can understand
1753 that there is a lot of concern out there about how this is
1754 actually going to play out in the lives of the people that we
1755 are so honored to serve.

1756 I guess one of the things, going back to--we know that
1757 CMS is prepared to survey consumers regarding the level of
1758 service and quality of care changes and the round two of the
1759 bid process of course is scheduled to begin in the spring of
1760 2011, but how can the surveys provide a quantitative analysis
1761 in order to determine the success of the program and to

1762 identify any shortcomings and how quickly will the surveys be
1763 completed and on what frequency?

1764 Mr. {Wilson.} I would have to get back to you with
1765 respect to some of the details of the survey. We will be
1766 conducting a consumer satisfaction survey. We have already
1767 done a pre-implementation survey to provide a baseline. So I
1768 think we will be moving forward quickly. I will provide to
1769 you specific information on when that follow-up survey will
1770 occur. But I think there are, you know, many other things
1771 that we will be doing in terms of monitoring. We will be
1772 collecting information from Medicare 1-800, from our
1773 ombudsman program so that we can review complaints, analyze
1774 complaints to see if there are systematic problems. I
1775 already mentioned the active claims surveillance that we will
1776 be doing. So we are really trying to look on a broad basis
1777 using a number of different tools to penetrate some of the
1778 issues and concerns.

1779 Ms. {Sutton.} Let me just follow up on that line real
1780 quickly here. What will happen if CMS identifies a reduction
1781 in quality and service? Is there a particular change that
1782 will trigger CMS's intervention? I mean, it is a very
1783 uncertain future.

1784 Mr. {Wilson.} I guess that could take many, many forms,
1785 and to the extent that it was a concern with respect to a

1786 particular supplier not meeting the quality standards or
1787 doing something in conflict with the quality standards, that
1788 may call for a certain typed of targeted intervention. If we
1789 found that there was a broader base concern, we would have to
1790 consider what that is, what the circumstances are and move
1791 swiftly to take appropriate action. So without sort of
1792 knowing what that is, it is hard for me to say.

1793 Ms. {Sutton.} I thank you, and Mr. Chairman, I have
1794 additional questions I will submit for the record.

1795 Mr. {Pallone.} Any member can submit additional written
1796 questions and we will ask you to get back to us fairly
1797 quickly if you can.

1798 Next is the gentleman from Texas, Mr. Burgess.

1799 Dr. {Burgess.} Thank you, Mr. Chairman.

1800 You know, as I sit here and we have this hearing and if
1801 I take myself back to July of 2008 when we passed MIPPA, you
1802 know, as I recall, we passed that under suspension. I don't
1803 think we had a markup here in the subcommittee. I don't
1804 think we had a markup in full committee on the delay of the
1805 competitive bidding program and it just underscores how when
1806 we circumvent the normal process, how harmful it is. It is
1807 harmful to businesses, it is harmful to patients and even the
1808 federal agencies are left trying to make sense out of what
1809 Congressional intent was. So while this committee probably

1810 didn't play a role in allowing MIPPA to come to the Floor
1811 without any discussion under suspension, it was wrong, it was
1812 a mistake, and I think going forward this committee needs to
1813 assert its authority at the subcommittee and full committee
1814 level.

1815 I am very grateful to our witnesses for being here
1816 today. Mr. Wilson, I know that you have heard from several
1817 members that here we are, now we have the 6-month anniversary
1818 of the Health Care Act coming upon us next week. The
1819 Secretary is going out with some re-education that she talked
1820 about in the newspapers last week. We haven't heard from
1821 her. I know she can't just show up to this committee. She
1822 has to be invited. I have here a copy of a letter. It is
1823 actually the second letter that Mr. Barton and I have
1824 submitted to Mr. Waxman asking him to invite the Secretary to
1825 come to the committee. I would ask you today, sir, would you
1826 be kind enough to carry a copy of my letter to Mr. Waxman
1827 asking him to invite the Secretary so that she may be
1828 prepared for that invitation when I hope it eventually comes?
1829 Can I ask you to carry this to the Secretary, sir?

1830 Mr. {Wilson.} Absolutely.

1831 Dr. {Burgess.} Thank you. A couple of questions then
1832 for you. You know, it appears as we go through this and
1833 hearing your testimony, some of these competitive bidding

1834 contracts, I mean, they are going to be--the amount of money
1835 coming in may be substantially reduced, and that may be
1836 entirely appropriate, but have you at HHS done any studies as
1837 to the market feasibility of removing this amount, these
1838 amounts of dollars from the business models of these
1839 companies that are the suppliers?

1840 Mr. {Wilson.} We have certainly examined the pricing
1841 structure and some of the business models closely.

1842 Dr. {Burgess.} So have you done studies as to the
1843 market feasibility?

1844 Mr. {Wilson.} I don't think we have done what I would
1845 call or describe as a market feasibility study the way a
1846 corporation might conduct such a study who wants to launch a
1847 product.

1848 Dr. {Burgess.} But the only reason a corporation would
1849 do it is because they want to be able to be competitive and
1850 provide the good or service to the person, the customer, the
1851 end user that needs it so it would make sense to do that.
1852 Well, let me just ask you, have you done any studies on how
1853 this would impact patient access to any of these supplies?
1854 We have heard several people mention that today, Cleveland
1855 clinic, I think Mr. Hall brought it up. Have you looked into
1856 that?

1857 Mr. {Wilson.} Yes, I think that we know is that many of

1858 the products through a number of different studies by GAO,
1859 OIG and our own analysis of some of the information that we
1860 have now from suppliers that many of the items under the
1861 current fee schedule are very overpriced.

1862 Dr. {Burgess.} And I don't disagree with that at all,
1863 and shame on us as a committee, shame on the federal agencies
1864 for not having addressed this problem sooner.

1865 Now, Mr. Levinson, since you are here, and I am so glad
1866 you are here, I don't really understand why you are here but
1867 I am glad you are here because we need to have this
1868 discussion, and in fact, I hope, Chairman Pallone, that you
1869 will convey to Mr. Waxman that it would be good to get Mr.
1870 Levinson and perhaps some of his counterparts at Department
1871 of Justice to come to our oversight committee and talk to us
1872 about this in some detail because in your written testimony
1873 you detail the importance of oversight, and honestly, it has
1874 been lacking over the last 3-1/2 years and I just hope going
1875 forward we can get that--we can have that happen. I see, you
1876 know, the television stories repetitively back in my home,
1877 basically the Dallas-Fort Worth television market, a
1878 gentleman comes home and finds a wheelchair in his living
1879 room they have never asked for. He is fully ambulatory and
1880 he can't understand why he has a wheelchair, and the reporter
1881 unraveling this Gordian knot comes back to the fact that he

1882 went someplace for some blood test some 6 or 12 months
1883 before. They got his billing information and through a
1884 convoluted series of different providers, now he ends up with
1885 a wheelchair in his house and he doesn't know what to do with
1886 it because his house is not able to accommodate a wheelchair
1887 and he doesn't need one. So these types of stories just
1888 drive people crazy, and in my discussion with your
1889 counterparts in our area and the Department of Justice, one
1890 of the problems that they have is the lack of federal
1891 prosecutors. When you guys develop a case and bring a case,
1892 the lack of federal prosecutors to then pursue that has been
1893 very, very difficult, and in fact, there was one foreign
1894 national who had multiple provider numbers. One provider
1895 number was shut down--and this was a home home, not a DME
1896 provider--but one provider was shut down but they kept
1897 cutting checks to the same person with different provider
1898 numbers and they all went to the same post office box. Have
1899 you got no mechanism within HHS to control for that seeming
1900 oversight, that we just keep sending checks to a post office
1901 that we know the lady's going to jail and we're sending
1902 checks to that same post office box? Are you working on
1903 that?

1904 Mr. {Levinson.} We certainly are working on it and we
1905 know that CMS is also working on it because it is extremely

1906 important to get the information technology right in order to
1907 be able to be, if not the head of that criminal element, at
1908 least able to quickly try to remedy that kind of problem,
1909 which has plagued the system for many, many years.

1910 Dr. {Burgess.} With all due respect, sir, sometimes it
1911 seems like we are not even fielding a team to oppose them.
1912 We invite them. We beg them, come take this money from us,
1913 we have too much, please take it. And we have heard it over
1914 and over again and it comes up in stories in our districts,
1915 and this is what is driving people crazy. We have got to be
1916 smarter. I mean, you referenced that perhaps there is an
1917 element of organized crime. We need to be smarter in dealing
1918 with that and the punishment needs to be swift and sure. We
1919 spend all this money going after mom and pops that are doing
1920 the right thing and taking care of our patients and we let
1921 the criminals escape.

1922 I realize I have gone over. Thank you, Mr. Chairman,
1923 for your indulgence. I will yield back.

1924 Mr. {Pallone.} Thank you.

1925 Dr. {Burgess.} Unless Mr. Levinson wants to respond to
1926 that.

1927 Mr. {Levinson.} Well, I think one of the most promising
1928 efforts just in the last couple of years has been the Strike
1929 Force effort that has developed between our Office and the

1930 degenerative joint disease with the help of CMS to close down
1931 fraudulent DME operators, especially in south Florida. The
1932 program is effective in southern California. We have
1933 important operations around the Gulf area. So I think there
1934 is an increasingly positive record of being able to really
1935 enforce the law when it comes to DME fraud that is returning
1936 millions and potentially billions to the trust fund. So this
1937 is actually a very important turnaround for the program and I
1938 would be happy to provide more detailed data.

1939 Dr. {Burgess.} I would be grateful for that.

1940 And Mr. Chairman, I would just reiterate my call that
1941 you ask Chairman Waxman to convene a subcommittee, an
1942 oversight--

1943 Mr. {Pallone.} I am not going to suggest anything to
1944 Chairman Waxman but I would say--

1945 Dr. {Burgess.} It is your duty.

1946 Mr. {Pallone.} --I would appreciate if you would get
1947 back to us further on that question that Mr. Burgess asked.

1948 The next is the gentlewoman from California, Ms. Eshoo.

1949 Ms. {Eshoo.} Thank you, Mr. Chairman. I think that
1950 this has been quite instructive, both the questions of the
1951 members and the answers and the testimony of the panelists,
1952 so thank you to Ms. King, to Mr. Wilson and to Mr. Levinson.

1953 Mr. Levinson, I was struck by many of the things you

1954 stated in your oral testimony, particularly the idea that
1955 overpayments, which we try to eliminate because they
1956 represent waste on their own terms, actually contribute to
1957 and exacerbate fraud. If we pay too much for something, we
1958 not only waste money on that purchase, I think we are at the
1959 same time creating a magnet to attract bad actors. I mean,
1960 we can't forget as we are concentrating on the dollars that
1961 are abused and the fraud that we know is in the system and
1962 how important it is to fight it that there are very honest,
1963 good people that own small businesses and do a very good job.
1964 I don't think that is what this hearing is about. That is
1965 certainly not my intent, but I am struck by the amount of
1966 money that you said in your first few sentences that. Was it
1967 \$20 billion or \$10 billion a year? I wanted you to restate
1968 that because I think everyone needs to hear that number
1969 again.

1970 And here are many questions to you. Can you give us any
1971 examples of the nexus between overpayments and fraud? And I
1972 think that you can probably do that off the top of your head.
1973 And in your testimony, your testimony mentions wheelchairs
1974 and negative-pressure wound therapy pumps. You say in your
1975 testimony that competitive bidding by connecting prices paid
1976 in the program to market prices could actually help address
1977 this problem. So can you elaborate on that, and I think that

1978 there is something that the subcommittee needs to re-
1979 appreciate all over again, that this new process that is
1980 being set up estimates that there would be \$20 billion in
1981 savings over 10 years, \$20 billion. I don't know the last
1982 time anyone ever saw that in their checking account. But
1983 those dollars, those precious dollars would be plowed right
1984 back into Medicare to offer direct services to seniors in
1985 this country. So we are talking big numbers and things that
1986 are really significant. So would you like to answer my
1987 questions?

1988 Mr. {Levinson.} Well, if I can please return to the
1989 numbers that I started off my testimony with, we are talking
1990 about approximately 11 million beneficiaries who have
1991 occasion to use DME good over the course of the year at a
1992 cost to the program of about \$10 billion. What I said
1993 thereafter was that CMS estimates that about half of the DME
1994 claims were paid in error. Now, errors--

1995 Ms. {Eshoo.} That is really stunning.

1996 Mr. {Levinson.} --have multiple causes. There isn't
1997 one--this isn't necessarily overt fraud, and it is important
1998 to understand that we are talking about a failure very often
1999 of documentation, and the problem with not getting accurate
2000 documentation of course is that you really can't account for
2001 exactly what was provided and for what reason and what

2002 appropriate cost. So documentation is really the lifeblood
2003 of the program, and when we are talking about an error rate
2004 that high, that does suggest a serious systemic problem just
2005 being able to--

2006 Ms. {Eshoo.} I would certainly say so if it represents
2007 50 percent. There is something really wrong with whatever
2008 system is there.

2009 Mr. {Levinson.} Yes. The nexus of fraud with
2010 overpayments is that if you have too much of a disparity
2011 between acquisition costs and the price, that actually does
2012 provide an incentive for those masquerading as legitimate,
2013 genuine DME suppliers as they come into the marketplace, and
2014 indeed, we do have a lot of pricing reports that indicate
2015 that there is a significant disparity between what CMS allows
2016 and what the actual acquisition costs or products like power
2017 wheelchairs, pressure wound therapy pumps, home oxygen
2018 equipment, we do have a body of work indicating that there
2019 are serious disparities that CMS needs to remedy and in many
2020 case hopes to remedy I think as a result of this program.

2021 Ms. {Eshoo.} Thank you very much.

2022 I think, Mr. Chairman, in this competitive bidding
2023 process that for the businesses that provide these services
2024 and equipment, they need consistency, they need clarity and
2025 they need to be able to participate in a fair way. They need

2026 to know where they stand and the process needs to be a very
2027 clear one, but make no mistake about this, I think the
2028 overriding issue here is, we do the right thing and in the
2029 right way, that this represents billions of dollars. This
2030 isn't any small thing.

2031 So I especially want to thank the OIG for the
2032 exceptional work. I think every Member of Congress should
2033 really read your report. It is outstanding. Thank you very
2034 much.

2035 Mr. {Pallone.} I thank the gentlewoman. I agree
2036 wholeheartedly with your last comments there. Thank you.

2037 Mr. Hall is next.

2038 Mr. {Hall.} Mr. Chairman, thank you.

2039 I join the parade as the gentlelady from Florida who
2040 asked you to take another look, Mrs. Eshoo that I have served
2041 with for many years here and I have very rarely ever found on
2042 the wrong side of anything, talks about a fair process and
2043 the bad actors. I would like to ask the GAO and OIG--I think
2044 that is Ms. King and Mr. Levinson--what are you doing and
2045 what is your opinion on the fact that Medicare plans to
2046 reimburse portable oxygen systems at an average of \$21 a
2047 month for as many fills or refills that the patient requires
2048 and wholesale cost with the highest volume discounts to just
2049 a liquid oxygen refill, not including equipment is \$30 more

2050 than what Medicare proposes in their single payment amount
2051 for portable oxygen? What is your opinion on that?

2052 Ms. {King.} Can we get back to you on that, sir?

2053 Mr. {Hall.} You have no opinion?

2054 Ms. {King.} I would have a more considered opinion if I
2055 had time to look at it more carefully.

2056 Mr. {Hall.} Will you do that?

2057 Ms. {King.} Yes, sir, I will.

2058 Mr. {Hall.} To Mr. Wilson, I would like to ask you, how
2059 can you justify a \$21 reimbursement for the portable liquid
2060 oxygen system when the cost to fill the liquid system is at
2061 least \$30 more than what you reimburse? Do you want to look
2062 at it some more too?

2063 Mr. {Wilson.} Well, I think what I would say,
2064 Congressman, is that we have looked pretty closely at oxygen
2065 equipment. We looked at the OIG reports and we looked at
2066 what we have been paying, and you can find this equipment for
2067 a lot less than we pay. If you look at our overall payments
2068 in oxygen in terms of the monthly amounts, we are paying
2069 excessively for oxygen, and I think the bids demonstrate
2070 that. And I would be happy to provide more-specific
2071 information about the prices that you are quoting. I just
2072 don't have those prices in front of me.

2073 Mr. {Hall.} That is fair enough. We can always ask you

2074 for them by letter and you would respond, wouldn't you?

2075 Mr. {Wilson.} We would be happy to submit them to you
2076 after the hearing.

2077 Mr. {Hall.} You have always claimed, I think, that you
2078 perform due diligence on providers and have assured that
2079 bidders are financially qualified. That is necessary, isn't
2080 it, in your opinion?

2081 Mr. {Wilson.} Yes, certainly.

2082 Mr. {Hall.} And you have problems with contracts, the
2083 out-of-area companies are companies that have no experience?

2084 Mr. {Wilson.} I don't think we saw a lot of those
2085 companies bidding in this process.

2086 Mr. {Hall.} You spoke in your opening remarks of smooth
2087 transactions and transitions and realistic bidding. You did
2088 state on the record that 30 percent of the bidding companies
2089 had questionable financials. You said that, haven't you?

2090 Mr. {Wilson.} I did not.

2091 Mr. {Hall.} You did not say that?

2092 Mr. {Wilson.} That quotation I have seen several times
2093 over the last few days. It is different in every version,
2094 and I would like to submit a statement for the record. I
2095 could tell you what I was referring to if you like, sir.

2096 Mr. {Hall.} I would like to hear anything. I am under
2097 the impression that you said that, but if you didn't say it,

2098 what did you mean to say--

2099 Mr. {Wilson.} What I was talking about--

2100 Mr. {Hall.} --on the record about bidding companies
2101 with questionable financials, because I am also told that you
2102 allowed them to proceed through the process, and that seems
2103 to me to be a disregard for your own directives, and if that
2104 is what you call a smooth transition, why, we have a
2105 different opinion on what a smooth transition is.

2106 Mr. {Wilson.} Well, that is right.

2107 Mr. {Hall.} And a lot of other people must, because my
2108 mail has been flooded with information on those things.

2109 Mr. {Wilson.} I think you would find, sir, that I
2110 probably agree with your position. That is certainly not
2111 what I said, so it is inconsistent with my view and my
2112 statements.

2113 Mr. {Hall.} Okay. You have offered contracts to out-
2114 of-area companies and you have offered contracts to those
2115 with little or no experience, have you not, providing
2116 competitively bid items and services?

2117 Mr. {Wilson.} Well, the information I was able to
2118 provide today, sir, is that about 72, 73 percent of all
2119 contract offers went to experienced local suppliers, those
2120 with experience in the product categories. Another 11
2121 percent went to experienced local suppliers that may have

2122 provided a different product category. Another 12 percent
2123 went to suppliers that were experienced in the product
2124 category but came in from the outside area. That leaves
2125 about 5 percent that I don't have information on. I expect a
2126 lot of those are mail order diabetic supply outfits that are
2127 set up out of state somewhere and because they operate
2128 through the mail.

2129 Mr. {Hall.} I ask also of the GAO, it is my
2130 understanding that you have done studies on wholesale
2131 purchase costs for oxygen concentrators but the question is,
2132 have the agencies done cost analysis on the other oxygen
2133 systems or any other oxygen system that patients are required
2134 to use for their daily living? Have the agencies done
2135 analysis on the cost to provide portable liquid oxygen
2136 systems that are necessary for patients that want to leave
2137 hospitals or visit their doctors or travel outside their
2138 bedrooms or maintain employment? Have they done studies on
2139 that?

2140 Ms. {King.} We have some work on oxygen payments that
2141 is currently underway and hasn't been released yet. We would
2142 be happy to provide you with that when it comes out. And if
2143 that doesn't answer your questions, you know, we could have
2144 further conversations.

2145 Mr. {Hall.} You are good on the word ``some'' there.

2146 How many is ``some''?

2147 Mr. {Pallone.} Mr. Hall, we will take that question but
2148 we are about a minute and a half over. So if you will answer
2149 his question--

2150 Mr. {Hall.} Then I will yield back the balance of my
2151 time.

2152 Mr. {Pallone.} No, we will let Ms. King answer that
2153 one.

2154 Ms. {King.} I didn't understand his question, sir. If
2155 you can repeat it, that would be helpful.

2156 Mr. {Hall.} No, that is all right. I will write you a
2157 letter and ask for that information, and I don't want an
2158 answer of ``some'' something. I would like an answer on the
2159 numbers if you have them because you know how many letters
2160 you have, you know how many inquiries you have made of Mr.
2161 Wilson, and his answer I think was some letters were written.
2162 I will clarify that in letters to you, and I thank you for
2163 your time.

2164 Ms. {King.} I will get back to you.

2165 Mr. {Pallone.} Thank you.

2166 Next is the gentlewoman from Florida, Ms. Castor.

2167 Ms. {Castor.} Thank you, Mr. Chairman, and thank you to
2168 the witnesses very much for your helpful testimony.

2169 The benefit of having durable medical equipment

2170 suppliers in local communities is that the companies and
2171 their staff are familiar with patients in their neighborhoods
2172 and are accessible for patients and their families in the
2173 event that they need assistance or service for their
2174 equipment. So a lot of the frustration you hear comes from
2175 all across the country in these small businesses that aren't
2176 the fraudulent companies but have been working very hard and
2177 providing good service, and it is just frustrating in this
2178 transition to competitive bidding to see contracts offered to
2179 out-of-area companies that may have little or no experience
2180 with durable medical equipment and services and have no
2181 familiarity with the area of service or direct access to
2182 patients that rely on their equipment, and will this be cost-
2183 effectiveness in the long run, and what I am hearing you all
2184 say is that we are going to monitor it, you are going to wait
2185 and see.

2186 Another concern is that there have been many complaints
2187 that the financial vetting process used in the competitive
2188 bidding process allows bankrupt companies or companies facing
2189 bankruptcy to win bids at rates 30 to 40 percent less than
2190 current reimbursement. Please explain this to me. What kind
2191 of financial vetting process do you have that allows bankrupt
2192 companies to win bids at 30 to 40 percent less than current
2193 reimbursement while you are also awarding bids to viable

2194 companies but they are saying that they are going to be
2195 subsidizing the patients but it makes sense for them to try
2196 to win these contracts because this competitive bidding
2197 process is so unpredictable?

2198 Mr. {Wilson.} At the outset, I would just say,
2199 Congresswoman, that I am not aware of any bankrupt companies
2200 winning contracts. I know there was some discussion in the
2201 trade press about a particular company that had a high debt
2202 talking about the potential for reorganization several years
2203 ago. They may have been considering reorganization. They
2204 may have been trying to pressure their creditors to give them
2205 a better deal. I don't know. We do know that we looked
2206 carefully at their financials. We used the same type of
2207 financial ratios that banks and other financial institutions
2208 to use the viability of an entity. This falls under our
2209 financial standards. It is the reason why we collect the
2210 documents such as tax records, credit history and things like
2211 that. So we did look at all those things for every--

2212 Ms. {Castor.} Okay. I am going to submit this
2213 information that was provided to me about the company in
2214 bankruptcy, and if you would take a look at it and respond
2215 back, I would appreciate it.

2216 Mr. {Wilson.} Absolutely. Thank you.

2217 Ms. {Castor.} And then one of my colleagues said when

2218 we are going to get smarter about health fraud, and I thought
2219 it was interesting because right now we are in the
2220 implementation phase of the new health care law that contains
2221 numerous anti-fraud provisions that will assist CMS and the
2222 Office of Inspector General and the Justice Department in
2223 identifying abusive suppliers and fraudulent billing
2224 practices including the new authorities to screen providers
2225 before they enter the program, the new requirements that
2226 physicians ordering DME be enrolled in the Medicare program,
2227 new data-sharing and data collection provisions, enhanced
2228 penalties for fraudulent providers and new funding to
2229 identify preventive and punish fraudulent providers. Where
2230 are you now in the implementation phase? What is your
2231 timetable for these provisions?

2232 Mr. {Wilson.} Those provisions fall within our Center
2233 of Program Integrity. I work within our Medicare fee-for-
2234 service policy component. I would be very happy to reply or
2235 respond for the record to you on those issues.

2236 Ms. {Castor.} Because certainly a lot of these new
2237 requirements to root out the fraudulent practices in Medicare
2238 must be taken into account in this DME transition to
2239 competitive bidding.

2240 Mr. {Wilson.} Well, I think they are absolutely
2241 important, I agree. There is a number of things that are

2242 required by the new law which will act to root out fraud here
2243 dealing with some of the issues that the Inspector General
2244 mentioned already in terms of documentation for claims.
2245 There is a new requirement for face-to-face visits with
2246 physicians to document physician orders for DME. I think
2247 that is going to be important.

2248 Ms. {Castor.} We have to do this because the bad actors
2249 in DME are painting a picture all across the country that
2250 anyone that is in this business is involved in fraud. That
2251 is why I think it is absolutely--and coming from Florida, I
2252 am particularly sensitive of especially the Tampa Bay area
2253 that is very different from Miami and south Florida and
2254 oftentimes a lot of small businesses in my area have to bear
2255 the burden that someone says I am a Medicare provider in
2256 Florida and people wonder, and that is not fair. Thank you.

2257 Mr. {Pallone.} Thank you, Ms. Castor.

2258 Mr. Shimkus.

2259 Mr. {Shimkus.} Thank you, Mr. Chairman, and I apologize
2260 for not being here for the opening testimony and statements.
2261 It is a busy time for many of us. I appreciate Ed Whitfield
2262 sitting in for me.

2263 First, Mr. Chairman, for the record I have two
2264 submissions that I would ask. One is from our colleague, Mr.
2265 Langevin, which you have seen, and also from the Diabetes

2266 Access to Care Coalition.

2267 Mr. {Pallone.} Without objection, so ordered.

2268 [The information follows:]

2269 ***** COMMITTEE INSERT *****

|
2270 Mr. {Shimkus.} Also, I don't know if it is appropriate
2271 but I see our colleague, Nancy Johnson, in the hearing room,
2272 and she has worked diligently in her time on Ways and Means
2273 in this field, and Nancy, it is good to see you. You are not
2274 hiding from me. I see you there.

2275 I am going to talk macro and then I am going to talk
2276 micro. The macro debate is this--and I am glad some comments
2277 were made about the health care law because everybody knows,
2278 I am a competitive market-based conservative. Now, we are
2279 the policy people. You all have to implement. In the
2280 private practice, auditing of payments happens for the most
2281 part before the checks get sent because the private sector
2282 doesn't want to lose the money and fraudulently spend money,
2283 and sometimes our constituents have terrible times because
2284 they are fighting with the auditors of the insurance
2285 companies or the HMOs begging for the check to be sent. In
2286 our system, we send the check. We are fee-for-service folks.
2287 We send the check, and we can send the check for multiple
2288 years to one single mailbox for millions of dollars and every
2289 candidate who runs for federal office when they talk about
2290 the funding problems of Medicare, what do we say? We are
2291 going to clean up waste, fraud and abuse, and what do we
2292 point to? We point to this. And that is the frustration,

2293 and I think it is a bigger problem than just getting our t's
2294 crossed and our i's dotted. It is a fundamentally different
2295 system of a one-payer system of fee-for-service that only
2296 worries about the expense after the fact versus someone who
2297 is watching the check and making sure the check is going to
2298 the right place before. It is a government model versus a
2299 private-sector competitive market model. That is the macro
2300 debate and that is kind of why we are here. But that is our
2301 discussion. You guys implement, and so we appreciate the
2302 challenges that you have.

2303 And also, you know, just adding to Dr. Burgess, we do
2304 have a new health care law that is kind of going down in that
2305 direction and it would be good for the Secretary to come talk
2306 to us, and now I am on record at every hearing asking for
2307 that so I will do that now and then I will do that this
2308 afternoon and I will continue that record of saying, you
2309 know, it is about time we at least had someone who wants to
2310 talk about this law because no one wants to, and I would
2311 pretty much argue that during the whole 6 weeks of break no
2312 one was talking about it. Well, we were talking about it but
2313 no one else was really defending the law out in America.

2314 Now to a micro issue which I know is important. It is
2315 important to the disabled community, it is important to some
2316 producers, so I am going to go to Mr. Wilson. Mr. Wilson, do

2317 you believe that a code that does not represent a distinct,
2318 homogenous group of products should be included in
2319 competitive bidding?

2320 Mr. {Wilson.} As a general matter, yes, it should be
2321 included.

2322 Mr. {Shimkus.} The final rule for competitive bidding
2323 stressed product categories would include items intended for
2324 similar medical condition. Do you believe that the intended
2325 uses of mobility and wound prevention and treatment are
2326 similar medical conditions?

2327 Mr. {Wilson.} If they are related products, yes.

2328 Mr. {Shimkus.} Well, you should know the direction by
2329 which I am heading, a litany of groups from the disabled
2330 veterans to the Christopher Reeves Foundation have raised
2331 concerns over seat cushions and mobility equipment being
2332 lumped in the same category and then you exacerbate skin type
2333 injuries and abrasions and really huge problems because they
2334 are in a unit versus separate. Given--and I don't think that
2335 is really debated. I would think that you could ask the
2336 physician community and I think you can ask the disabled
2337 community, I don't think this is a--I have seen them.

2338 If that is the case, shouldn't we reconsider the
2339 inclusion of these type of products in the future?

2340 Mr. {Wilson.} I don't personally see a reason for

2341 reconsidering their inclusion. That said, we have not
2342 posted, made a decision on what items will be included in
2343 round two. But for this round, I think it is important that
2344 they be included. We think that the prices are excessive--

2345 Mr. {Shimkus.} Let me end up. The letter from Mr.
2346 Langevin, one of our colleagues, one of the really well-
2347 respected members who has led us in a new era of
2348 understanding the disabled community I think has a very
2349 strong position, and I would hope that the Administration
2350 would listen to him and other people who feel that this
2351 policy is harmful and I would suggest we take a look at it
2352 again, and with that, Mr. Chairman, I yield back.

2353 Mr. {Pallone.} Thank you.

2354 Mr. Braley.

2355 Mr. {Braley.} Thank you, Mr. Chairman.

2356 Mr. Wilson, I am going to start with you. I wasn't here
2357 when competitive bidding was made law, but isn't it true that
2358 there is a lot of ways that you can address the issues of
2359 waste, fraud and abuse that wouldn't involve competitive
2360 bidding?

2361 Mr. {Wilson.} There are certainly many ways for
2362 addressing this problem.

2363 Mr. {Braley.} And in fact, in Mr. Levinson's written
2364 testimony that he has provided to the committee, he documents

2365 a lot of the work that the OIG has done to try to address the
2366 enormous problem we have in health care delivery with waste,
2367 fraud and abuse, and at the conclusion of his
2368 recommendations, he notes, ``It is critical that these and
2369 other program vulnerabilities be addressed be it through
2370 competitive bidding or otherwise," and that ``otherwise'' is
2371 a huge sector of health care delivery that involves diligent
2372 oversight and management. You would agree with that?

2373 Mr. {Wilson.} That is certainly one of the areas that
2374 we would need to pursue in order to solve this problem.

2375 Mr. {Braley.} Has CMS to your knowledge done an
2376 analysis of the impact of the competitive bidding process,
2377 not just the initial phase but as it is intended to be
2378 implemented throughout its entirety on rural health care
2379 delivery?

2380 Mr. {Wilson.} We have not done that type of analysis to
2381 this point because rural areas are excluded from the program.
2382 We have not yet done rulemaking on how to expand the use of
2383 those prices by 2016 where we would do such an impact
2384 analysis.

2385 Mr. {Braley.} Do you understand why patients in rural
2386 America have serious concerns about a shrinking market to
2387 meet their health care demands if the impact of the long-term
2388 competitive bidding process results in the shrinking or

2389 available suppliers and an unwillingness on the part of some
2390 of the remaining people who are eligible to participate to go
2391 into areas where volume will not allow them to achieve the
2392 type of margins they could have factored in when they
2393 presented their initial bid application?

2394 Mr. {Wilson.} I think that what beneficiaries need is
2395 choice and quality and I think that can be sustained under
2396 this program.

2397 Mr. {Braley.} Are you aware that in a host of other
2398 purchasing opportunities that people in rural America have
2399 substantially fewer choices in the marketplace than people in
2400 more populated areas?

2401 Mr. {Wilson.} I think it is certainly true that there
2402 are challenges in rural health care.

2403 Mr. {Braley.} Have you ever lived in rural America, Mr.
2404 Wilson?

2405 Mr. {Wilson.} I have not.

2406 Mr. {Braley.} Well, I have. I grew up in a town of
2407 1,500, and most of my district is considered rural America,
2408 and we see lots of policymakers who come to committee
2409 hearings like this and try to tell us how they are going to
2410 fix the problems in rural America but I can tell you that for
2411 those of who deal with these problems on a daily basis, this
2412 is more than just paranoia. This is what we have seen happen

2413 on the storefronts and shops in our cities and towns. It is
2414 a problem where every time a drugstore goes out of business
2415 in a rural community it denies access to people who need
2416 durable medical equipment. Every time a provider who is
2417 furnishing DME services to those small town hospitals and
2418 health care providers, once they go out of business, we
2419 aren't as confident maybe as CMS is that the big players are
2420 going to be willing to come to our part of the country and
2421 continue to compete for our health care dollars. Do you
2422 believe that a decrease in the number of supplies in rural
2423 areas could impact accessibility and timeliness of receiving
2424 durable medical equipment?

2425 Mr. {Wilson.} I am not sure that we are going to see a
2426 decrease in suppliers in rural areas. I think we have not
2427 moved forward with the authority that we have to apply the
2428 prices in rural areas, and of course, competitive bidding
2429 does not apply there.

2430 Mr. {Braley.} Well, as Johnny Cash sang, ``I hear the
2431 train a comin, '' and I think everybody in rural America knows
2432 that this is inevitable.

2433 Mr. Levinson, I really was interested in a number of the
2434 comments that you made in your report. I want to focus on a
2435 few of those. You appropriately noted the challenges that we
2436 are facing in health care. We talk about this on this

2437 subcommittee. And dealing with what some people have
2438 identified as a \$500 billion to \$700 billion problem in this
2439 country, not just in Medicare and Medicaid but across the
2440 health care reimbursement system in waste, fraud and abuse,
2441 and you have identified enrollment, payment, compliance,
2442 oversight and response issues that need to be addressed. One
2443 of the things you talked about was that DME is one of those
2444 areas where we see problems with people getting in at the
2445 entry level and then it becomes hard to monitor them once
2446 they are set up and doing business, but I guess I am a little
2447 confused because if the purpose of having a certification
2448 requirement that a good or service is medically necessary
2449 before it can be prescribed and paid for by public or private
2450 reimbursement systems, why is it a challenge for anybody
2451 receiving Medicare payments, whether they are DME providers,
2452 pharmaceutical providers or other health care providers to be
2453 identified at the point of entry and be held to a level of
2454 accountability that protects consumers of health care in this
2455 country?

2456 Mr. {Levinson.} Well, over time it has certainly become
2457 apparent that it has been too easy to get a provider number.
2458 Enrollment has been a fundamental flaw for many years in
2459 terms of just gaining entry to the program. When our
2460 auditors and evaluators, for example, went to south Florida a

2461 couple of years ago and just banged on doors or tried to bang
2462 on doors because actually there were no doors to bang on, we
2463 found that about one-third of the 1,500 or 1,600 DME
2464 providers in south Florida, those who had registered and
2465 gotten a number, didn't make even the most basic standards
2466 for being able to gain entry to the program like having a
2467 physical location, like having regular hours, staffed by
2468 somebody who could actually help. So it is quite clear that
2469 it has simply been too easy to gain access, and to the extent
2470 that we can fix the enrollment issue among those five issues
2471 that you and we have identified, you really solve a lot of
2472 the consequential issues that we have to deal with when it
2473 comes to compliance, oversight and response. It doesn't
2474 necessarily deal with pricing methodologies with being able
2475 to align prices so that they better reflect market realities,
2476 and some of our pricing reports indicate that Medicare indeed
2477 pays too much and, you know, we have done some comparative
2478 work, much as with VA, which one might argue is a different
2479 kind of structure but with a federal employee health benefits
2480 program as well and with Internet pricing.

2481 So the pricing issues are perhaps somewhat related to
2482 enrollment but I think that the enrollment issue to the
2483 extent that we can get on top as a department of the
2484 enrollment issues, that will solve a lot of the blatant fraud

2485 issues, and again, you know, fraud is a segment of a larger
2486 issues but one of the most promising aspects actually of the
2487 Affordable Care Act is the mandating of a compliance program
2488 for health care providers, and I think by having compliance
2489 built in to Medicare going forward across a wide range of
2490 industries, we will be able to do a much better job of
2491 protecting taxpayer dollars and actually giving value to
2492 beneficiaries.

2493 Mr. {Braley.} Thank you for your time. I yield back.

2494 Mr. {Pallone.} Next is the gentleman from Maryland, Mr.
2495 Sarbanes.

2496 Mr. {Sarbanes.} Thank you, Mr. Chairman.

2497 Mr. Wilson, I just want to make sure I understand the
2498 problem. I got here a little bit late but I did watch some
2499 of it on the monitor. The fee schedule that was put in place
2500 back in the late 1980s, that has continued to inflate over
2501 time and therefore bears much less connection, any kind of
2502 rational connection or reasonable connection to the actual
2503 pricing structures out there, at least with respect to some
2504 of these durable medical equipment items, correct?

2505 Mr. {Wilson.} That's correct.

2506 Mr. {Sarbanes.} And the unreasonable relation is that
2507 it is paying a lot more in many instances and one could
2508 justify just looking at the market so the competitive bidding

2509 process is a response to that, and we talked about what some
2510 of the issues are with that process.

2511 I had a couple questions. One was, where else has CMS
2512 done this kind of competitive bidding as a response to
2513 similar kinds of issues and what has the experience been with
2514 that? And what are the reasons you go the competitive
2515 bidding route as opposed to just working harder to come up
2516 with a fee schedule that bears a more reasonable relationship
2517 year in and year out to the underlying market and price
2518 structures that are out there?

2519 Mr. {Wilson.} I think this program is pretty unique for
2520 Medicare. There has been a lab demonstration on competitive
2521 bidding. There are, I think, really not many other examples
2522 that would be even close to this type of program, and I think
2523 going to your second question, this program has a unique set
2524 of challenges in terms of setting prices and calculating or
2525 computing a new fee schedule. There is a lack of data on
2526 what items actually cost, so I think one of the reasons for
2527 competitive bidding was going to the only place to get to a
2528 true market price, which was the suppliers and bidding.

2529 Mr. {Sarbanes.} I guess drug pricing is another place
2530 where the data sets are pretty opaque in terms of
2531 understanding why things cost what they do.

2532 Mr. {Wilson.} I am less familiar with that program. It

2533 doesn't fall within my purview. But, you know, I think it is
2534 an area where manufacturer information is one of the only
2535 areas to get pricing information.

2536 Mr. {Sarbanes.} When the original fee schedule was
2537 established, would you say it was easier to get hold of the
2538 kind of data that could construct a fee schedule at that time
2539 than it is now or that was just the method to be used at that
2540 point with all the flaws that it bore?

2541 Mr. {Wilson.} Historically, there was a quote, unquote,
2542 reasonable charge-based payment system, essentially some
2543 discount off charges provided by suppliers. That was the
2544 only information available. Those charges were in many cases
2545 inflated or distorted but they were locked into the fee
2546 schedule for 20 years.

2547 Mr. {Sarbanes.} And just in terms of the details of the
2548 competitive bidding process, I don't know enough about how it
2549 is set up but are there baskets or ranges or parameters or
2550 corridors in which the competitive bids can be submitted or
2551 is this sort of anything goes in terms of being able to enter
2552 the bid process?

2553 Mr. {Wilson.} We--

2554 Mr. {Sarbanes.} In other words, is it kind of a managed
2555 competitive bid process in that sense or--

2556 Mr. {Wilson.} Well, I think it is a managed process in

2557 that we have a number of different criteria for qualifying
2558 suppliers to bid that relates to quality standards, financial
2559 standards, licensing, other things, and then we have
2560 processes to verify that bids are what we call bona fide. We
2561 try to ensure that they are not submitting a low-ball
2562 speculative bid.

2563 Mr. {Sarbanes.} But there is no, like, floor, for
2564 example, on what the bid can be?

2565 Mr. {Wilson.} No, there is not a floor other than the
2566 ability to document that a price is rational and feasible to
2567 provide the service. There is a ceiling which is the current
2568 fee schedule.

2569 Mr. {Sarbanes.} Okay. Thanks.

2570 Mr. {Pallone.} Thank you.

2571 Mr. Doyle.

2572 Mr. {Doyle.} Thank you, Mr. Chairman, and I want to
2573 thank the subcommittee's courtesy for allowing someone who is
2574 not a member of the subcommittee to ask some questions.

2575 I have the privilege of representing Pittsburgh in the
2576 Congress, and Pittsburgh was one of the nine round one test
2577 sites, and obviously I have been hearing from many of my
2578 constituents in the Pittsburgh area that I think have very
2579 valid concerns. Mr. Chairman, I have more questions than I
2580 have time for so I would like to submit additional questions

2581 for the record to maybe get them answered. One parallels Ms.
2582 Castor's concern about a company that announced it was
2583 awarded 17 contracts, and this is a company that had publicly
2584 said back in May that if they couldn't get their debt down
2585 they were filing for bankruptcy in the spring. So we do have
2586 concerns that we are not giving contracts to companies that
2587 aren't going to be able to sustain themselves, and it is one
2588 of the real concerns we have in Pittsburgh too with these
2589 bids coming in at seemingly artificially low prices just for
2590 companies that want to sustain themselves and stay in
2591 business whether these companies are going to be able to be
2592 viable 3 years down the road at some of these prices that
2593 they are competing with.

2594 Before I get into that, I have a specific question on
2595 glucose testing strips I want to ask you. Diabetes is a big
2596 problem in my district, and I have concerns about the
2597 availability of glucose testing strips. My understanding
2598 that mail order suppliers are required only to carry one
2599 brand and not necessarily the brand that patients use, and as
2600 you know, these strips are unique to the machines that they
2601 use just like razor blades are to certain razor handles. And
2602 I understand that DME providers are permitted to provide a
2603 monetary incentive to patients to switch monitors if they
2604 can't get the test strips to go with their monitors, but a

2605 lot of my patients in Pittsburgh, we have an elderly
2606 population. They are seniors. It is very problematic for
2607 them having to switch monitors, and what I want to know is,
2608 how does CMS know that the suppliers are going to be able to
2609 furnish the volume of specific products that will be demanded
2610 through the competitive bidding program? For example, does
2611 CMS know, for instance, that suppliers who contract for
2612 Pittsburgh will be stocking and selling strips that work with
2613 Lifescan's One Touch Ultra meters. Thirty-five percent of my
2614 district uses that monitor. And if a supplier chooses not to
2615 offer strips that work with Life Scan's One Touch Ultra or
2616 any other brand strips that a beneficiary uses, what options
2617 are available to that beneficiary to obtain replacement
2618 stripes?

2619 Mr. {Wilson.} If I could just go back and reference a
2620 few of the statements that you made, sir. We don't
2621 specifically say you are only required to provide one brand
2622 of test strips. In fact, when I look at the bid information
2623 that came in, and we collect information on all the models,
2624 products and services that will be provided under the program
2625 and will update it quarterly, I see a full range of products
2626 in the particular ones that I have looked at.

2627 Mr. {Doyle.} Are you saying you don't require them only
2628 to carry one brand, you require them to carry multiple

2629 brands?

2630 Mr. {Wilson.} We require them to submit a bid on
2631 brands, on the brands that they intend to provide.

2632 Mr. {Doyle.} Are they required to carry more than one
2633 brand?

2634 Mr. {Wilson.} We don't say that, no, sir.

2635 Mr. {Doyle.} So theoretically, they could carry one
2636 brand and be in compliance with the bid?

2637 Mr. {Wilson.} Theoretically, but that is in fact not
2638 what happens because suppliers come in, they want business.
2639 They know they need to provide the items that beneficiaries
2640 want if they are going to be viable.

2641 The other thing that I would say is, I am not aware of
2642 any ability to offer a monetary incentive. I am not the OIG.
2643 That would possibly implicate anti-kickback, although I won't
2644 make that judgment. That is for others.

2645 Mr. {Doyle.} So tell me, what happens to--let us just
2646 say for instance if I have seniors in my district that have a
2647 monitor that needs a specific test strip and it's not
2648 available, what are their options?

2649 Mr. {Wilson.} Their options are several. If it is not
2650 available, and we certainly hope and expect that it will be,
2651 they could talk to their doctor about physician authorization
2652 requirement, the law which allows them to certainly pursue

2653 something that is medically necessary from a supplier. We
2654 have not bid test strips in retail stores. A beneficiary
2655 could obviously go to any retail store in Pittsburgh and--

2656 Mr. {Doyle.} Yes, but doesn't that sort of defeat the
2657 purpose of the competitive bidding program if they end up
2658 going to the pharmacies? I am going to submit more
2659 questions. Boy, 5 minutes goes fast. Because I want to ask
2660 you another question before my time is up.

2661 You know, a lot of people on the surface don't have a
2662 problem with this idea of competitive bidding so long as it
2663 doesn't affect quality and access, and I think that is really
2664 the concern that we have about this quality and access, and I
2665 know CMS is surveying customers regarding the level of
2666 service and quality of care changes. My question is, what
2667 happens if there is an identification of a change in quality
2668 or service? Is there some percentage or formula that would
2669 trigger some event or reaction by CMS and doesn't it concern
2670 you that your analysis of round one won't be complete before
2671 you expand this program to an additional 91 areas in round
2672 two? How do we measure quality of care and access and at
2673 what point is that is not happening? Is there a definitive
2674 formula? Is this subjective? You know, tell me how that is
2675 going to work.

2676 Mr. {Wilson.} Well, first of all, we are concerned

2677 about any concern, whether it a systemic concern or
2678 individual beneficiary concern and we will be collecting
2679 information and have the infrastructure in place to evaluate
2680 those and deal with them.

2681 The other thing I would say is that we are evaluating
2682 the program phase by phase as we move forward. I mentioned
2683 that we are going to be collecting claims data, active claims
2684 surveillance as the program moves forward so, you know,
2685 beginning very soon after January when the claims start
2686 coming in, we will be able to see what is going on. We will
2687 see who the beneficiaries are, whether they are going to the
2688 doctor's office, the emergency room, other types of problems.

2689 Mr. {Doyle.} And if you are seeing these problems in
2690 quality of service and access, how will you respond to that?
2691 How do you change what you are doing?

2692 Mr. {Wilson.} Well, we will have to examine the
2693 particular situation and see what the problem is. We will
2694 have to identify whether it is a particular problem with
2695 suppliers not meeting quality standards, whether it is
2696 particular suppliers having other types of difficulty. But
2697 we will certainly collect that information and examine it.

2698 Mr. {Doyle.} Mr. Chairman, you have been very generous
2699 with your time and I appreciate it, and I will submit the
2700 rest of my questions for the record.

2701 Mr. {Pallone.} Absolutely. And let me--

2702 Mr. {Doyle.} And so has the ranking member.

2703 Mr. {Pallone.} Oh, yes, and the ranking member.

2704 Let me mention, we had an unusual number of members
2705 actually who said they are going to submit written questions,
2706 which is fine. We try to get them to you within 10 days.
2707 The clerk will try to get them to you within 10 days and then
2708 of course we would like you to get back to us as quickly as
2709 possible. I don't think I have ever had a hearing where
2710 there were more members who said they were going to submit
2711 written questions. So thank you very much and I appreciate
2712 your input on such an important subject. Thank you. And I
2713 will ask the second panel to come forward.

2714 Let me welcome the second panel and introduce each of
2715 you again. From my left is Ms. Karen Lerner, who is a
2716 Registered Nurse with Wound Care, Support Surface, and she is
2717 also a Rehab Specialist at Allcare Medical. Where is Allcare
2718 Medical located?

2719 Ms. {Lerner.} Sayreville, New Jersey.

2720 Mr. {Pallone.} Sayreville, New Jersey. You are my
2721 witness. I mentioned it earlier, and I was hoping that I was
2722 going to mention that again. Thank you.

2723 And then Mr. Alfred Chiplin, Jr., who is Managing
2724 Attorney for the Center for Medicare Advocacy. And Ms. Nancy

2725 Schlichting, who is President and CEO of Henry Ford Health
2726 System. I am going to ask where that is also.

2727 Ms. {Schlichting.} In Detroit.

2728 Mr. {Pallone.} In Detroit. And Dr. William Scanlon,
2729 who is a Health Policy Consultant. Where are you from, Dr.
2730 Scanlon?

2731 Mr. {Scanlon.} Washington.

2732 Mr. {Pallone.} From Washington. All right.

2733 As I think I mentioned before, we try to keep everything
2734 to 5-minute opening statements. I think the panelists have
2735 been pretty good about sticking to the 5 minutes. It is the
2736 members that have not, so I am not going to say anything
2737 further, but if you want to submit additional written
2738 comments as a follow-up, you may well.

2739 And I will start with Ms. Lerner.

|
2740 ^STATEMENTS OF KAREN LERNER, REGISTERED NURSE, WOUND CARE,
2741 SUPPORT SURFACE AND REHAB SPECIALIST, ALLCARE MEDICAL; ALFRED
2742 CHIPLIN, JR., MANAGING ATTORNEY, CENTER FOR MEDICAL ADVOCACY;
2743 NANCY SCHLICHTING, PRESIDENT AND CEO, HENRY FOOD HEALTH
2744 SYSTEM; AND WILLIAM SCANLON, HEALTH POLICY CONSULTANT

|
2745 ^STATEMENT OF KAREN LERNER

2746 } Ms. {Lerner.} Mr. Chairman and members of the
2747 subcommittee, my name is Karen Lerner and I am a Registered
2748 Nurse and Wound Care Support Surface and Rehab Specialist for
2749 Allcare Medical in Sayreville, New Jersey. Allcare has been
2750 in business since 1963. We have 200 employees and serve
2751 about 25,000 patients per year. Allcare Medical is a member
2752 of the Jersey Association of Medical Equipment Services and
2753 the American Association for Home Care.

2754 I am here today representing the home care community.
2755 My goal is to explain why this competitive bidding program as
2756 designed by CMS will not achieve its desired outcomes and
2757 will in fact reduce access to care for Medicare
2758 beneficiaries, lower the quality of that care, increase cost
2759 and kill jobs.

2760 We agree with the 255 members of the House of

2761 Representatives who believe this program should be scrapped.
2762 Numerous consumer and patient advocacy organizations also
2763 believe the bidding program should be eliminated. The
2764 fundamental flaw in the design of this bidding program for
2765 durable medical equipment is that it treats home medical
2766 equipment and services like a simple commodity. We are not
2767 equipment deliverers; we are service provider.

2768 In fact, effective home-based care for our Nation's
2769 seniors and people with disabilities is an integral part of
2770 the continuing care that helps move patients from hospital to
2771 the home. It helps to keep people out of nursing homes and
2772 the emergency room and it reduces hospital admissions. Many
2773 frail, elderly and disabled Medicare beneficiaries require
2774 multiple items of medical equipment. Consider the chaos that
2775 will occur when a caregiver must call five or six different
2776 companies to coordinate the medical equipment needs of a
2777 patient who requires a hospital bed, support surface, oxygen,
2778 enteral feedings and a walker. I have seen many, many
2779 patients like this. As a Nurse and an Assistive Technology
2780 Professional who helps patients get fitted for the right type
2781 of wheelchair, I am in contact with patients every day, and
2782 it scares me to think of what will happen to these patients
2783 if this bidding program becomes reality.

2784 The current marketplace without competitive bidding

2785 requires home care providers to compete for patients on the
2786 basis of service and choice to furnish the home medical
2787 equipment that makes the most clinical sense for the
2788 beneficiary. We are currently reimbursed under fee schedule
2789 in Medicare CMS and Congress have cut repeatedly and
2790 disproportionately over the past decade so the contention
2791 that the DMEPOS fee schedule is outdated and is based on
2792 pricing from 25 years ago is incorrect. The home medical
2793 equipment sector has already seen reimbursements cut nearly
2794 50 percent to the Medicare fee schedule over the past decade.
2795 Despite all the quality assuring and measuring tools that CMS
2796 has previously touted, patients and even most physicians will
2797 not know if they are getting clinically appropriate equipment
2798 and services until negative outcomes appear.

2799 With respect to all of the promised savings and
2800 advantages of the competitive bidding program, I maintain
2801 that what sounds too good to be true is too good to be true.
2802 This ill-conceived program will single-handedly destroy the
2803 home medical service sector, harm the patients we serve and
2804 ultimately increase Medicare costs.

2805 Now let me describe the problems we have seen in the re-
2806 bid process. A provider in Ohio was offered a contract for a
2807 respiratory device but they didn't have a respiratory
2808 therapist on staff contrary to the bidding rules and contrary

2809 to Ohio law. One of the largest home care companies
2810 announced in July 2010 that it was offered 17 contracts in
2811 the first bid despite the fact that in June 2010 it had \$513
2812 million in long-term debt, was considering restructuring or
2813 filing for bankruptcy and expects to lose up to \$900,000 in
2814 the bidding areas in the first quarter of 2011.

2815 Let me speak to the issue of transparency. One hundred
2816 and thirty-six members of Congress who sent a letter to CMS
2817 recently believe that CMS has not shared enough information
2818 about the program. Transparency is intended to protect the
2819 public. The lack of transparency makes deficiencies in the
2820 program and makes it impossible to evaluate fully the way CMS
2821 reached its various decisions at every stage of the process.
2822 From an Administration that touts its openness and
2823 transparency, we have seen none with this program.

2824 On the question of fraud prevention, first let me say
2825 that home medical equipment providers have no tolerance for
2826 fraud but arbitrarily limiting the number of legitimate
2827 providers in the marketplace will do nothing to stop those
2828 whose only intent is to defraud the Medicare program. The
2829 HME community should not be penalized when CMS grants
2830 Medicare billing credentials to an empty closet. The
2831 government is simply not doing an adequate job of site
2832 inspections before awarding suppliers. As a Nurse and with

2833 direct experience in the home care medical field, I believe
2834 this program will increase costs rather than save money.
2835 Patients I see will suffer through limited access to
2836 clinically appropriate equipment and services. It will
2837 reduce the quality of equipment beneficiaries receive and
2838 many will end up in the hospital. This program will not be
2839 fixed as it is designed. Therefore, JAMES, AAHomecare and a
2840 large number of patient organizations believe that Congress
2841 must immediately stop the implementation of this bidding
2842 program and work with the HME community to ensure accurate
2843 pricing while at the same time ensuring access to quality
2844 care for Medicare beneficiaries.

2845 Thank you again for the opportunity to provide
2846 testimony.

2847 [The prepared statement of Ms. Lerner follows:]

2848 ***** INSERT 4 *****

|
2849 Mr. {Pallone.} Thank you, Ms. Lerner
2850 Mr. Chiplin.

|
2851 ^STATEMENT OF ALFRED CHIPLIN, JR.

2852 } Mr. {Chiplin.} Good afternoon, Mr. Chairman.

2853 The Center for Medicare Advocacy takes a wait-and-see
2854 approach to the competitive bidding process. We acknowledge
2855 that it is a program that is extremely complex and confusing.
2856 Our beneficiary clients have been the victims of many efforts
2857 of misinformation. They have been frightened and confused
2858 about what this program means.

2859 We continue to worry about the complexity of the program
2860 overall and the impact of that complexity on provider and
2861 supplier participation and thus access to specific services
2862 and items of DME that people might want.

2863 We also are concerned that CMS's efforts at beneficiary
2864 education need to be more vigorous and visible. We think we
2865 need more to assure beneficiaries that where there might be
2866 fewer suppliers in this competitive bidding area that that
2867 will not jeopardize access.

2868 Some major concerns that we have is that we do see that
2869 there is put forth a strong beneficiary education and access
2870 program and that the time of that education effort be very
2871 clear and specific as different phases of the competitive
2872 bidding process are rolled out. This is such a critical

2873 thing because over time this approach will redefine how all
2874 of DME is going to be meted out and I think that raises a
2875 very significant set of points.

2876 We also need to have better information on the website
2877 for the Medicare beneficiaries, Medicare.gov. It is
2878 difficult to find information about the competitive bidding
2879 process. We also need better information points to access
2880 written materials. And additionally, we need more clarity
2881 about the specific items that fall within the initial
2882 rollouts of the program in 2011 so the beneficiaries have
2883 more clarity about that.

2884 We also need additional information about the importance
2885 and significance of beneficiaries obtaining their DME within
2886 the competitive bidding area in which they live. There are
2887 real consequences for beneficiaries, particularly if they are
2888 traveling on vacation and something happens and they need to
2889 get an item fixed. So those are the kinds of concerns. As
2890 the rollout goes on with mail orders, we think some of the
2891 same kind of issues are raised in terms of the degree to
2892 which beneficiaries are informed.

2893 Thank you, Mr. Chairman.

2894 [The prepared statement of Mr. Chiplin follows:]

2895 ***** INSERT 5 *****

|
2896 Mr. {Pallone.} Thank you, Mr. Chiplin.
2897 Ms. Schlichting.

|
2898 ^STATEMENT OF NANCY SCHLICHTING

2899 } Ms. {Schlichting.} Good afternoon, Chairman Pallone,
2900 Ranking Member Shimkus, Congressman Dingell and members of
2901 the subcommittee. My name is Nancy Schlichting. I am the
2902 President and CEO of the Henry Ford Health System in Detroit,
2903 Michigan, and thank you so much for the opportunity to
2904 testify.

2905 I appear today on behalf of hospitals and health systems
2906 that own and operate their own durable medical equipment
2907 services. We are deeply concerned about the impact of
2908 competitive bidding on our patients and costs unless the
2909 program can be revised to protect our health care delivery
2910 model. The key value of our organizations is the ability to
2911 integrate and coordinate post-acute care with hospital care.
2912 Over the past 3 years we have worked as an informal coalition
2913 of hospitals and health systems in 22 States that have their
2914 own DME and other post-acute services as a tool for improving
2915 quality and safety and service for our patients while
2916 controlling costs. Durable medical equipment is one of many
2917 services housed within our health system that allow us to
2918 better manage and deliver patient care. All business units
2919 including DME are aligned to coordinate and integrate care at

2920 the best price in a very competitive marketplace with growing
2921 burdens of uncompensated care.

2922 One of our primary goals is to provide a smooth
2923 transition between hospital and home so that patients can
2924 leave as soon as they are clinically ready and make beds
2925 available for new patients. In addition to reducing the
2926 length of stay, we also work to prevent unnecessary
2927 readmissions and to lower the use of the emergency
2928 department.

2929 The ability to own and control virtually every aspect of
2930 patient care including DME is essential to our success.
2931 Members of our coalition are large and small and most are
2932 organized similar to Henry Ford Health System. Our coalition
2933 includes the Michigan Health and Hospital Association and
2934 many of the Nation's premier health systems such as the
2935 University of Michigan, University of Iowa, the University of
2936 Pittsburgh Medical Center, Advocate Health in Illinois,
2937 Aurora Health Care in Wisconsin, BayCare in Florida, the
2938 Cleveland Clinic and SUMMA Health System in Ohio, Banner
2939 Health in Arizona and Colorado, Providence in Oregon and
2940 Washington, and Meridian Health in New Jersey.

2941 Two of our members, BayCare and the University of
2942 Michigan, have done studies showing that patient care and
2943 cost would be adversely affected by the competitive bidding

2944 as it is now structured. The Michigan study showed that the
2945 aggregate median length of stay for referrals managed by
2946 hospital-based services was 5.3 days compared to 6.8 days for
2947 referrals managed by non-hospital based services

2948 I want to note that we have not opposed competitive
2949 bidding. From the beginning our goal has been to advocate
2950 for the flexibility we need to manage patient care in a
2951 structure where pricing is the same for all DME providers in
2952 the area. In today's hospitals, patient discharges take
2953 place throughout the day. In many cases, the ability to send
2954 a patient home or into nursing care depends on the
2955 availability of numerous items of DME: a hospital bed,
2956 surgical or diabetic supplies, wheelchair, a commode or
2957 oxygen. Coordinating the supply and delivery of DME is
2958 critical to avoiding extra days in the hospital, extra days
2959 that Medicare, Medicaid and private insurers will not pay for
2960 immediately, but these costs do get folded into the overall
2961 cost of health care.

2962 When DME and other post-acute care is aligned with the
2963 hospital, we can respond to the demands of Medicare and
2964 private insurers for better care at a lower cost and less
2965 complexity for the patient and family. Having to use an
2966 outside DME supplier, or several suppliers in the case of
2967 complex patients, destroys this crucial alignment and

2968 perpetrates an inefficient and costly delivery system. Even
2969 though extra days in the hospital may not immediately and
2970 directly cost Medicare Part A more, the cost for unnecessary
2971 days remains in the health system and eventually everyone
2972 pays for it. Savings estimates for competitive bidding focus
2973 primarily on price reductions for durable medical equipment
2974 under Part B. What is left out of the picture are the
2975 increased costs that the hospital and within our health
2976 systems.

2977 A number of health systems in our coalition are affected
2978 by phase one, which begins January of 2011, and very few have
2979 been awarded contracts for Medicare patients. Cleveland
2980 Clinic in Ohio and UPMC in Pennsylvania receive no contracts
2981 and are now shut of Medicare for DME services. Some other
2982 systems receive contracts for only one or two items. These
2983 results go in the wrong direction. For these health systems
2984 and hospitals, costs will be higher than necessary and
2985 support for families caring for elderly patients in the home
2986 will be lost. Instead of support and convenience, there will
2987 be 1-800 telephone numbers and multiple suppliers who often
2988 tell families calling to report malfunctioning equipment that
2989 they should go to their nearest ER.

2990 Finally, we have been advised by CMS that the Secretary
2991 has no discretion in this matter and that there can be no

2992 administrative solution without additional legislation.
2993 While we have had good and constructive discussions with CMS,
2994 especially on the importance of integrated care as a tool for
2995 helping with issues of cost, CMS says that Congress must act.
2996 To address this problem, we have worked with Congressman
2997 Dingell and he has introduced H.R. 6095, giving qualified
2998 health systems that own and operate a DME entity the ability
2999 to continue to serve its patients at a reimbursement rate
3000 determined by the competitive bidding process for its region.
3001 We believe this is a limited, reasonable and commonsense
3002 remedy and we thank Mr. Dingell for his support and
3003 understanding as well as his remarks this morning. The bill
3004 will preserve savings associated with lower prices for DME
3005 services and allow us to preserve a critical patient
3006 management tool that allows us to save money and better serve
3007 the patients that come to us every day for quality medical
3008 care.

3009 On behalf of our coalition, I ask for your support for
3010 Mr. Dingell's bill and will be pleased to answer any
3011 questions. Thank you very much.

3012 [The prepared statement of Ms. Schlichting follows:]

3013 ***** INSERT 6 *****

|

3014 Mr. {Pallone.} Thank you.

3015 Dr. Scanlon.

|
3016 ^STATEMENT OF WILLIAM SCANLON

3017 } Mr. {Scanlon.} Thank you very much, Mr. Chairman.
3018 Chairman Pallone, Ranking Member Shimkus and members of the
3019 subcommittee, I am pleased to be here as you review the
3020 implementation of Medicare's durable medical equipment
3021 competitive bidding program.

3022 I am an economist who has been involved in health policy
3023 research for 35 years. Until 2004, I was the managing
3024 director of health care issues at the U.S. General Accounting
3025 Office. I have also been a member of the Medicare Payment
3026 Advisory Commission, completing my second term this past May.
3027 My views today are my own and do not reflect those of any
3028 organization with which I have been affiliated.

3029 Competitive bidding for durable medical equipment is one
3030 step in attempting to make the Medicare program a more
3031 efficient purchaser of services. There have been
3032 longstanding concerns about the level and growth of Medicare
3033 spending that growth while mirroring other sectors of health
3034 care has consistently exceeded the growth of GDP, inflation
3035 and the beneficiary population and imposes an increasing
3036 burden on taxpayers as well as on beneficiaries in the form
3037 of higher Part B premiums and cost sharing. It is essential

3038 to ask whether the program is being as efficient as possible
3039 in maintaining access to medically necessary services for its
3040 beneficiaries.

3041 Efforts to make Medicare a more efficient purchaser have
3042 been underway for many years. Beginning in the early 1980s,
3043 Medicare payment methods for most services have been reformed
3044 in fundamental ways. DME payments stand out as an exception.
3045 This is despite a large body of evidence produced by the
3046 Department of Health and Human Services' Office of Inspector
3047 General and the GAO on how much Medicare payments exceed the
3048 prices charged to retail customers or a supplier acquisition
3049 costs. You have heard examples in today's testimonies.

3050 Efforts to refine Medicare DME payment levels
3051 administratively have proven very cumbersome. The burden of
3052 collecting sufficient retail price or acquisition cost data
3053 to change prices is formidable and only a limited number of
3054 prices have been changed over the years. Even when those
3055 data are available, setting an efficient price for the
3056 Medicare program is problematic. Medicare as a major
3057 purchaser should not have to pay retail prices to obtain
3058 beneficiary access. The advantages to suppliers of being
3059 able to sell to Medicare are likely sufficient to make them
3060 willing to offer Medicare a discount.

3061 Competitive bidding offers an alternative to setting

3062 prices administratively which is less burdensome and more
3063 likely to result in better prices for the program. Suppliers
3064 have the incentive to offer better prices to be able to win a
3065 contract. The potential of competitive bidding has been
3066 demonstrated by the price reductions in the Texas and Florida
3067 demonstrations authorized by the Balanced Budget Act and in
3068 the two rounds of bidding under the Medicare Modernization
3069 Act authorized program.

3070 Suppliers' willingness to offer prices is predicated on
3071 their expectation that winning a contract will result in a
3072 bigger market share. For this to be true, Medicare has to
3073 move away from its traditional any-willing-provider approach
3074 and limit the number of winning contracts. This is a
3075 significant change and there are legitimate concerns about
3076 potential disruptions and negative impacts on beneficiaries
3077 and providers. Taking steps to minimize such impacts and
3078 ameliorate them promptly is essential because the importance
3079 of making Medicare a more efficient purchaser cannot be
3080 ignored.

3081 Two important steps to reduce some of these disruptions
3082 that have been taken are to award multiple contracts in each
3083 area and to award small businesses a very significant share
3084 of contracts. This preserves a range of supplier choices for
3085 beneficiaries. These provisions strike a balance between

3086 reducing potential disruptions and getting a better price for
3087 the program. Having more winners lowers bidders' incentives
3088 to offer lower prices. While having more winning contracts
3089 may result in somewhat higher prices in the short term, it
3090 also is likely to keep the program competitive over the
3091 longer term and guarantee savings in the future.

3092 How the program is implemented on the ground as well as
3093 its design are incredibly important to minimizing disruption.
3094 As you have heard from Ms. King, there were legitimate
3095 concerns about the aspects of implementation in the first
3096 round of bidding in 2007. Some of the shortcomings
3097 identified in that first round may be the unfortunate but
3098 very common outcome of introducing such fundamental change.
3099 Substantial change requires a learning process on the part of
3100 providers and beneficiaries as well as CMS. This learning
3101 should not, however, be allowed to be a gradual process. It
3102 is important that CMS invest heavily in provider and
3103 beneficiary education and in monitoring the process of
3104 bidding and contract awards.

3105 Requesting bids and securing better prices is only the
3106 first phase of making Medicare a more efficient, prudent
3107 purchaser of DME. Continued oversight to assure that access
3108 to and quality of products purchased meet expectations is
3109 also essential. Congress has required GAO to provide a

3110 report on the experience with the program including
3111 beneficiary access and satisfaction, quality issues, impacts
3112 on suppliers, especially small businesses, and opportunities
3113 for greater efficiencies. CMS needs to be able to answer
3114 those same questions on an ongoing basis. Simply identifying
3115 problems, however, is not sufficient. CMS also must be in a
3116 position to be able to resolve them as quickly as they are
3117 identified.

3118 Let me end by underscoring, making the Medicare program
3119 a more efficient purchaser is critical to preserving access
3120 for beneficiaries and keeping the program more affordable for
3121 both taxpayers and beneficiaries. Competitive bidding for
3122 DME provides an opportunity to improve program efficiency.
3123 Competitive bidding itself, though, is only about setting the
3124 price. How one administers the purchasing of the products
3125 after contracts have been awarded is critical to assuring
3126 that the goals of access and quality are preserved. These
3127 things cannot be understated.

3128 Thank you very much, Mr. Chairman. I would be happy to
3129 answer any questions you or members of the subcommittee have.

3130 [The prepared statement of Mr. Scanlon follows:]

3131 ***** INSERT 7 *****

|
3132 Mr. {Pallone.} Thank you, Dr. Scanlon, and we will have
3133 questions now from the members.

3134 I guess I have to start with Ms. Lerner's doomsday
3135 scenario because she really did paint a picture. I mean, I
3136 am looking at the written testimony where she says we are
3137 going to drive thousands of qualified HME providers out of
3138 the Medicare marketplace and the result is a loss of ability
3139 to serve patients, layoffs, business failures, etc. I mean,
3140 obviously that is the concern, and of course, Mr. Chiplin was
3141 talking about how beneficiaries need to understand that their
3142 provider might change, and a lot of people are going to
3143 actually end up having a change in providers, so to speak.

3144 But I wanted to go back to what Ms. Lerner said and I
3145 wanted to ask her and maybe Dr. Scanlon along those lines, I
3146 mean, basically the argument is that Medicare will contract
3147 with a reduced number of DME suppliers relative to the number
3148 of suppliers enrolled today, that competition will actually
3149 decreased under competitive bidding and over time this will
3150 actually lead to an increase in prices because there will be
3151 fewer bidders. Is that part of what you are saying, Ms.
3152 Lerner? I will start with you and then I will ask Dr.
3153 Scanlon the same thing, if you think that that is a
3154 convincing argument, and even if prices were to rise somewhat

3155 above the 32 percent savings projected by CMS for the round
3156 one re-bid, it would seem to me that prices would have a long
3157 way to go upwards to get back to current levels. So my
3158 question is, is this just a question of the competition? I
3159 mean, I know you mentioned all the problems with layoffs.
3160 Are you also arguing, Ms. Lerner, that competition is going
3161 to disappear and that ultimately we are going to end up--is
3162 that ultimately going to cost us more in the future or is it
3163 just the fact that we are going to have fewer suppliers and
3164 you are worried about the layoffs, so to speak?

3165 Ms. {Lerner.} No, I think the competitive bidding bill
3166 is inherently anti-competitive. Studies show that 75 percent
3167 to 90 percent of the suppliers will not be able to compete in
3168 the marketplace and will be forced out of business or be
3169 acquired by existing DME. We are reimbursed by Medicare by
3170 product code. It doesn't matter the cost of the product, has
3171 no relevance to how we are reimbursed. So it is a
3172 competitive marketplace. We offer a better product. There
3173 are other clinicians that are--

3174 Mr. {Pallone.} The problem is--I know I am interrupting
3175 you. You know, we have heard all the testimony earlier about
3176 how there are so many of these providers out there. It is
3177 very easy to get in the business. They are charging too
3178 much. Medicare is losing money. There is fraud. I mean,

3179 obviously the competitive bidding was a response to that. I
3180 mean, you have to kind of tell me where you think we are on
3181 the spectrum. In other words, you don't see the competitive
3182 bidding as actually helping us in dealing with all this
3183 excessive cost; you think the opposite is going to happen?

3184 Ms. {Lerner.} I absolutely think the opposite will
3185 happen. I think because of increased ER visits, readmissions
3186 to hospital and not being able to discharge a patient, those
3187 are all costs that need to be factored in. I think Ms.
3188 Schlichting said length of stay is going to increase in a
3189 hospital because by the time you call five or six providers,
3190 one for the bed, one for the support surface, one for oxygen,
3191 you can't get them out of the hospital so they are going to
3192 stay in the hospital longer. Hospital stay is much more
3193 expensive than home care.

3194 Mr. {Pallone.} Let me ask Dr. Scanlon to respond to
3195 this. She makes a good argument. What do you say?

3196 Mr. {Scanlon.} I think it is important sort of to go
3197 back to one of the things that I mentioned, which is that
3198 there has been a balance struck in the way this program is
3199 being designed. Rather than being more aggressive in terms
3200 of trying to get the best price and awarding, say, only a
3201 single contract for a product in an area, there is going to
3202 be an award for multiple contracts and including sort of a

3203 proportion of those contracts going to small businesses.

3204 This is a part of maintaining sort of robust--

3205 Mr. {Pallone.} So you don't see this argument that
3206 competition is actually going to decrease and the costs will
3207 start to go up again?

3208 Mr. {Scanlon.} I think there will be adequate
3209 competition over time. There will be a decrease in the
3210 number of suppliers but I think one of the questions we
3211 should be asking ourselves is, how many suppliers of DME
3212 should we have. There is a strong contrast between DME
3213 suppliers, the supply of DME sort of providers and suppliers,
3214 with the other types of providers in the Medicare program.

3215 Mr. {Pallone.} But you don't see the competition--

3216 Mr. {Scanlon.} No. We have 100,000 DME suppliers
3217 compared to the--the next biggest number is 16,000 nursing
3218 homes.

3219 Mr. {Pallone.} All right. Let me ask Mr. Chiplin just
3220 because I am trying to keep to the time, although I am
3221 failing here, what about the whole education process? In
3222 other words, you know, obviously a lot of people are going to
3223 have a different provider. They may not know it. And I
3224 guess CMS has some kind of program to provide for this
3225 transition but what is your opinion of that? Is that good
3226 enough or do you want to comment on it a little bit?

3227 Mr. {Chiplin.} Well, I applaud them for what they are
3228 doing. I know they have a very complex program to implement
3229 and to explain to beneficiaries. Our concern is that the
3230 beneficiary education effort to this point has been rather
3231 invisible. It is hard to find things, as I said, on their
3232 website. I think there needs to be more attention to those
3233 kinds of details about where you put beneficiary information
3234 and how it is made available to people. I think those are
3235 some of the fundamental things that can happen that will
3236 allow advocates such as our organization to have better
3237 access at trying to find the bits and pieces of information
3238 that can be translated into pamphlets and other things that
3239 would be of help to beneficiaries in understanding the
3240 program going forward. So I think one of the fundamental
3241 things with respect to beneficiary education, that it
3242 shouldn't be viewed as just an add-on the process but it
3243 should be an integral part of the rollout all the way across
3244 the board.

3245 Mr. {Pallone.} All right. Thank you. My time has run
3246 out.

3247 Mr. Shimkus.

3248 Mr. {Shimkus.} Thank you, Mr. Chairman. I have not a
3249 lot of time and a lot of questions so I am going to try to go
3250 quickly.

3251 Ms. Lerner, as an RN and as a provider of DME equipment,
3252 are all seat cushions equal?

3253 Ms. {Lerner.} Not by a long shot.

3254 Mr. {Shimkus.} And let me follow up. Do patients have
3255 different needs for different seat cushion arrangements?

3256 Ms. {Lerner.} Of course.

3257 Mr. {Shimkus.} And that kind of segues into the
3258 previous panel and this whole issue about lumping them in in
3259 the process, and I think many of us would argue that they
3260 should be separate. Let them compete but let them be
3261 separate based upon patient need.

3262 Dr. Schlichting, I have been following Chairman Emeritus
3263 Dingell's bill. There are some compelling arguments in
3264 support of that legislation because in the bidding process--I
3265 don't know, I am not the person doing the bidding process but
3266 you would think--again, this is the difference between
3267 government and the competitive marketplace. If I was doing a
3268 bid contract and I needed stuff 24/7, I think I would write
3269 that into my bid process, but obviously CMS does not do that,
3270 and the concern is, no matter how the system--you just can't
3271 get the equipment on hand or the patient can't get it to
3272 leave in a timely manner through the hospital. Is that a
3273 simple synopsis of the concern? So you want to control that
3274 so you can move on?

3275 Ms. {Schlichting.} Well, you know, I think for any of
3276 us who have had to navigate through health care in this
3277 country, ways that we can make it simpler for patient and
3278 families and improve the efficiency by having that control of
3279 the continuum, we find that it has a real added value and
3280 that is what we are trying to preserve in this legislation.

3281 Mr. {Shimkus.} Well, we definitely haven't moved in
3282 simplicity in the last 18 months.

3283 Off the DME thing for a second. You are aware that the
3284 Administration's own Chief Actuary of Medicare estimated that
3285 15 percent of hospitals will become unprofitable based upon
3286 the health care law. You are probably big enough that you
3287 are not one of them. Is that, am I safe to assume?

3288 Ms. {Schlichting.} Well, actually, one of the reasons
3289 we are profitable is the integration that we created Henry
3290 Ford. We have a salaried medical group. We have ambulatory
3291 and full continuum of care services, and we have a very high
3292 uncompensated care burden in Detroit as our flagship provider
3293 is one of the safety net providers in the State.

3294 Mr. {Shimkus.} But you wouldn't dispute the 15 percent
3295 from the actuary talking about hospitals throughout the
3296 country who will probably have to close because of the
3297 provision?

3298 Ms. {Schlichting.} I can't speak to that, but I do

3299 think there will probably be more consolidation to create
3300 more efficiency of care.

3301 Mr. {Shimkus.} Which is language for closures. Thank
3302 you.

3303 Let me go to Dr. Scanlon real quick. Can't we put on
3304 quality measures for the bidding process to meet Ms.
3305 Schlichting's need for 24/7 delivery of equipment?

3306 Mr. {Scanlon.} Certainly we can make that a
3307 requirement. I think on of the things that we need to think
3308 about are the contract specifications. What does it take to
3309 be a qualified provider. If that turns out to be one of the
3310 essential attributes, then we should make that a requirement.
3311 One of the instructive things about looking at the Veterans
3312 Administration is that they have used competitive bidding for
3313 a long time and they have actually have had stronger
3314 specifications in terms of the products they receive and
3315 services they receive than does the Medicare program.

3316 Mr. {Shimkus.} And let me go, because of your expertise
3317 in government health care and also your experience in being
3318 an accountable. The health care law, do you believe it will
3319 lower costs or the deficit?

3320 Mr. {Scanlon.} The deficit is a macroeconomic issue
3321 which is well beyond a health economist's purview so let me--

3322 Mr. {Shimkus.} No, that is not true because there is a

3323 Medicaid expansion in the bill and it is projected by
3324 obviously the executive branch to be \$10 million and we think
3325 more likely it will be \$30 million, which is a burden to us,
3326 which is a burden to the States, especially who is a 50
3327 percent payer.

3328 Mr. {Scanlon.} I know, and I think I want to leave that
3329 to CBO in terms of--

3330 Mr. {Shimkus.} I deal with the Army War College and we
3331 prepare them for Congressional testimony. One thing when I
3332 do talk to these soon-to-be senior leaders is that you better
3333 be prepared to answer any questions. You are an accountant,
3334 so I would expect--that is the advantage and disadvantage of
3335 coming before us.

3336 Quickly, Mr. Chiplin, the final question for you is, if
3337 there are \$575 billion cuts in Medicare reported by the Chief
3338 Actuary, is that harmful to senior citizens on Medicare?

3339 Mr. {Chiplin.} Well, that is a very big number you just
3340 recited. It depends. I think the question really would be,
3341 where would those cuts come?

3342 Mr. {Shimkus.} Well, they are coming from Medicare.

3343 Mr. {Chiplin.} But I mean, even having said that, what
3344 particular services are cut, what access there might be that
3345 has been traded off in some--

3346 Mr. {Shimkus.} Would it be safe to say that there is

3347 some concern?

3348 Mr. {Chiplin.} Absolutely. That has been my testimony
3349 all along. I am not saying--

3350 Mr. {Shimkus.} Right, and I got it. Thank you very
3351 much.

3352 Yield back, Mr. Chairman.

3353 Mr. {Pallone.} Thank you, Mr. Shimkus.
3354 Chairman Dingell.

3355 Mr. {Dingell.} Thank you, Mr. Chairman.

3356 These questions to Ms. Schlichting. Are you for or
3357 against competitive bidding?

3358 Ms. {Schlichting.} Well, as part of this process, we
3359 have been very clear about the fact that we are not taking a
3360 position on competitive bidding. We accept competitive
3361 bidding as part of the process and we are trying to make sure
3362 that we have clarity around those organizations that are
3363 hospitals and health systems that have DME, that they will be
3364 able to continue to provide that integrated care.

3365 Mr. {Dingell.} Thank you.

3366 Now, Congress has delayed competitive bidding for 18
3367 months with a 10 percent price cut. In addition, Congress
3368 provided for an exemption for hospitals for certain products.
3369 Now, why is it that we need the legislation, H.R. 6095, that
3370 you have been discussing?

3371 Ms. {Schlichting.} There were two issues there. One is
3372 that it really only identified hospitals as opposed to health
3373 systems, and we need broader inclusion of health systems in
3374 the legislation, and secondly, it didn't include all products
3375 frankly that hospitals and DME providers supply.

3376 Mr. {Dingell.} Would you submit to the committee the
3377 products that were not included that really should have been
3378 in there?

3379 Ms. {Schlichting.} We will be happy to do that.

3380 Mr. {Dingell.} Now, when I go into the hospital, I walk
3381 out, if I have had a broken leg or something, they give me a
3382 boot or they give me crutches or they hand me a cane and then
3383 they give me pills and such as that, or if I have had surgery
3384 on my eye they give me shields for the eye and things of that
3385 kind. If this is to be done by then some third party, how is
3386 that the hospital without the language of H.R. 6095 is going
3387 to properly be able to assign what it is I need and see to it
3388 that I have at expeditiously when I depart the hospital to go
3389 home?

3390 Ms. {Schlichting.} Hospitals may continue to provide
3391 certain elements that are absolutely essential for that
3392 patient to walk out the door but what they won't be able to
3393 do is provide those needed services in the home so that they
3394 get home safely, they have what they need. It is more

3395 complicated certainly for patients and families who often end
3396 up being the one that have to secure some of those needed
3397 supplies and equipment. So we believe that there is a much
3398 greater opportunity if our health systems have the chance to
3399 really fulfill all those needs.

3400 Mr. {Dingell.} Thank you. Now, the exemption that we
3401 have referred to earlier does not mean that hospital-based
3402 companies do not have to be accredited like everybody else.
3403 Isn't that so?

3404 Ms. {Schlichting.} That is correct.

3405 Mr. {Dingell.} Thank you. Now, CMS rules allow for
3406 smaller DME suppliers to form networks and to participate in
3407 Medicare as network suppliers. Why is this not a solution
3408 for hospital-based companies?

3409 Ms. {Schlichting.} Well, it basically still won't allow
3410 for the hospital-based companies to compete in terms of the
3411 size and scope of most of the hospital-based organizations so
3412 we believe again that the opportunity to create the
3413 integration at the hospital and health system level is very
3414 important.

3415 Mr. {Dingell.} Now, Ms. Schlichting, you have attached
3416 a study by the University of Michigan Health System. They
3417 looked at a longer length of stay for patients when they were
3418 outside the home, or rather when outside the home care

3419 providers were used. Can you elaborate on this and do you
3420 think that this is representative of the experiences of the
3421 other members of your coalition?

3422 Ms. {Schlichting.} We believe it is. In fact, the
3423 University of Michigan is much like Henry Ford. It is a very
3424 large health system. And they looked at considerable detail
3425 around this over a three-month period, and another of our
3426 members, BayCare, also studied the impact, and in cases where
3427 the hospital did not use its own DME but was required by
3428 insurance contracts to use outside suppliers, there were
3429 extra days in the hospital, higher readmissions and more use
3430 of the ER as compared to outside providers.

3431 Mr. {Dingell.} Thank you.

3432 Now, Dr. Scanlon, how many major suppliers of durable
3433 medical equipment will there be in this country because of
3434 the concentration of power and market in the hands of a few
3435 dominant distributors of these commodities under the form
3436 that we are discussing today? Just give me the number, if
3437 you please.

3438 Mr. {Scanlon.} I am afraid I don't have the number. I
3439 can say that it is totally a function of how CMS awards the
3440 contracts, what kinds of targets they set in terms of how
3441 many--

3442 Mr. {Dingell.} Then answer this question. First of

3443 all, the number will be reduced, yes or no?

3444 Mr. {Scanlon.} Yes, it will. It is 100,000 now.

3445 Mr. {Dingell.} And what will that do with regard to
3446 competition elsewhere in the industry with regard to other
3447 people? There will be less competition for their business
3448 because there are going to be a few very dominant larger
3449 suppliers, right?

3450 Mr. {Scanlon.} I think there will be fewer suppliers
3451 and some reduction in competition but there may still be
3452 ample competition to keep prices at reasonable levels.
3453 Medicare is about a quarter of the durable medical equipment
3454 market, so three-quarters of the revenues are coming from
3455 other purchasers.

3456 Mr. {Dingell.} My time is running out, and this
3457 question is very important. But then we are going to
3458 confront a situation where there will be just a few dominant
3459 suppliers in any of the regional markets that are being
3460 created by this matter by concentrating the power in the
3461 hands of just a few suppliers. For example, in our Detroit
3462 area there will probably only be one. Maybe in New York
3463 there will be five or six. But that will be instead of a
3464 much larger number of people we have doing business there.
3465 Isn't that going to be a consequence of this?

3466 Mr. {Scanlon.} I think that again it is going to depend

3467 upon how CMS chooses to award contracts, what kinds of
3468 requirements they have for local presence because a large
3469 company may be able to supply a very large share of the
3470 market to mail order but may not be able to supply sort of
3471 things locally when it requires a physical presence in each
3472 area.

3473 Mr. {Dingell.} There is nothing to say that one of
3474 these near monopolists is not going to all of a sudden decide
3475 well, by golly, I think this would be very nice if we all of
3476 a sudden went into the mail order business, and using that
3477 the power that they have of the economy for large sales
3478 stimulated by their recognition under Medicare they can all
3479 of a sudden then dominant not only the market for Medicare
3480 supplies but also the mail order supplies because of the
3481 market power they have and do like the Japanese do,
3482 subsidized because of the monopoly in their own market.

3483 Mr. {Scanlon.} Again, I think that that scenario
3484 depends upon sort of how CMS chooses to award contracts--

3485 Mr. {Dingell.} Are either--

3486 Mr. {Scanlon.} --what kinds of specifications they have
3487 that would allow the transfer of--

3488 Mr. {Dingell.} Are either of these scenarios that I am
3489 discussing illogical or improbable?

3490 Mr. {Scanlon.} They are not impossible. I would say

3491 that I do not expect them in the intermediate term.

3492 Mr. {Dingell.} So we can figure that perhaps the
3493 millennium has descended upon us. The good Lord will assure
3494 us that these untoward events will not be visited us by the
3495 monopoly that we are creating. Am I right or wrong?

3496 Mr. {Scanlon.} I think you are right.

3497 Mr. {Dingell.} Thank you.

3498 Thank you, Mr. Chairman, for your courtesy.

3499 Mr. {Pallone.} Thank you.

3500 Thank you again, I mean, obviously this is very spirited
3501 because there are areas where you agree and there are other
3502 areas where you disagree, but I think the bottom line is that
3503 this was very helpful to us today in terms of oversight of
3504 what is going on with this issue. Again, you may get
3505 additional questions from us, usually within 10 days, from
3506 the clerk in writing and get back to us as soon as possible.
3507 I think that this hearing today was extremely helpful in
3508 terms of knowing some of the problems but also we are going
3509 to have to dig a little deeper as well. So thank you very
3510 much.

3511 Unless anyone else has any questions, without objection,
3512 this hearing of the subcommittee is adjourned. Thank you.

3513 [Whereupon, at 1:30 p.m., the subcommittee was
3514 adjourned.]