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Statement of Dino Martis, President, Ablecare Medical to the Committee on Ways and Means, Subcommittee on Health

Hearing on the Medicare Durable Medical Equipment Competitive Bidding Program

May 9, 2012

Chairman Herger and Ranking Member Stark, I am pleased to provide my thoughts on the Medicare Durable Medical Equipment competitive bidding program. I am the President of Ablecare Medical, Inc., a small business based in Cincinnati and Cleveland, Ohio that began operations in 1991. We have been in business now for 20 years and are a full-service Respiratory and DME company. Currently, Ablecare Medical has 42 employees and strives to efficiently provide the highest quality services to the 3,000 Medicare patients who depend on us to provide their care.

My testimony today is based on my two decades of experience in providing services to America's seniors, both as part of the fee-for-service program and, more recently, as a successful contract awardee in the DME competitive bidding program.

Numerous studies have documented the problems in Medicare's DME benefit: inappropriate reimbursement; fraud; lack of clearly defined services and outcomes. Competitive bidding has brought some pressure to bear on those problems, but concerns remain. Fortunately, the debate is no longer centered on whether reimbursement should be reformed and whether competitive bidding is the right approach. The focus has now shifted to how competitive bidding should be structured moving forward. Based on my experience in rounds one and two, I believe additional modifications should be made to the program, but that these changes are minor.

Competitive bidding is working, and we are excited about our involvement in the program. We remain optimistic the competitive bidding approach holds great potential to improve care while lowering costs. We should also not lose sight of additional reforms that bring competition and technology to bear on the pressing problems of poor outcomes, quality measurement and high costs in DME markets.

Medicare Reimbursement for DME Prior to Competitive Bidding

The Government Accountability Office and others have documented the extent of overpayments for DME over the last two decades. Taxpayers and beneficiaries have paid for products that in some instances are hundreds of times greater than market rates. Likewise, GAO and the Health and Human Services Inspector General found problems in documenting actual services provided to beneficiaries and the quality of those services[1]. Our industry as a whole was unable to show a positive correlation between prices and clinical outcomes. The reasons for this include:

- DME companies are paid separately for clinical services and DME products under fee-for-service. The only incentive to provide clinical services under the fee schedule is if those services are required under a referral.

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[1] See, for example the testimony and reports at: http://www.gao.gov/archive/1998/he98102.pdf; http://www.gao.gov/assets/100/97606.pdf; http://oig.hhs.gov/testimony/docs/2002/020611fin.pdf

- There currently are no standards for measuring how equipment and services affect beneficiary outcomes or treatment costs. Clinical guidelines used by each HME company are different. In part, this may reflect the lack of standardization of clinical processes and measures.

- Industry billing and reporting systems do not necessarily keep track of hospitalizations or disease exacerbations, so it is unclear whether clinical services are positively impacting beneficiary health.

The reimbursement prior to competitive bidding was not sustainable given continually rising healthcare costs and expected growth in Medicare and Medicaid populations over the next decade. As I noted, Medicare reimbursement was well above market rates for both product and any services that could be reasonably provided in delivering the product. This Committee has heard testimony about beneficiaries paying more in cost sharing for certain DME than the typical cost of purchasing the equipment outright. These situations sow distrust in the Medicare program by eroding confidence that Congress and CMS are capable of designing systems to pay for services based on old fashioned commonsense.

Value of Competitive Bidding

As we have seen in other health services, economic hardship has depressed patient utilization of health services. It has been our experience over the last few years that consumers – Medicare and private plan enrollees alike – are reducing demand for provider services in general, and for equipment services in particular, due to the combination of falling incomes and rising cost sharing requirements.

With the introduction of competitive bidding, CMS has reduced the out-of-pocket burden for beneficiaries, many of whom are on fixed income, by lowering the costs of DME and, by extension, the required beneficiary cost sharing. From my perspective the benefit to DME companies is a greater probability that there will be more beneficiaries who are better engaged in their care over the long term because they are using the products as recommended by their physician. This will likely increase volume which, in turn, will compensate for lost reimbursement. The obvious additional benefit is a healthier, more functional beneficiary population.

Our Experience with Round One of Competitive Bidding

Our experience with Round One of competitive bidding was not uniformly positive. While the CMS interface and procedure for bid submissions were reasonably functional, there were instances where the system would go down and we would not be able to enter information required for bid submission. For example, we were unable to bid on the category for walkers. In all fairness, however, we delayed submission of our bids until the last day, and it is possible that others also did the same, creating a spike in server volume that caused intermittent system crash.

We learned from our experience, and in Round Two we entered our bids well in advance of the due date. As a result, we were able to enter our information for all categories for which we intended to submit bids without incident. Thus, the bid submission system in our experience worked as intended.

Competitive bidding has forced changes in our business, but not as commonly reported. Beneficiaries in our Cincinnati and Cleveland bid areas did not lose access or see a drop in service. No competitive bid winner would turn down a referral or provide sub-par service as such business practices would impact their ability to garner future referrals. Competitive bidding has likewise forced changes across our industry, but these changes are no greater than what every other industry experiences when forced to compete. To continue operation, we have had to become more efficient. We have learned how to use technology to our benefit. Manufacturers and other vendors have accepted the inevitability of the new, more competitive system and have made changes to their organizations that have enhanced efficiency. The resulting changes will allow us to reduce our bids and pass those savings onto to taxpayers and beneficiaries.

It is our belief, proven by working in this environment for the last 16 months, that the competitive bid program as structured by CMS will allow us to service all beneficiaries in our area at lower costs and better quality, with no reduction in service. Increased volume replaces what was lost in profit per sale. It is our belief that, as the economy strengthens and beneficiaries feel more financially comfortable, engagement and referrals will return to normal levels and, in fact, increase as more beneficiaries (i.e. baby boomers) enter the Medicare program.

Expectations in Round Two

In Round 2, we bid in those areas in Ohio where we knew we could afford to expand and provide personalized product and service to beneficiaries. Therefore, we did not bid in any area outside of Ohio. Because our experience with competitive bidding has been positive, we are excited about the prospect of expanding our quality services to more Medicare beneficiaries for more products in round two of the competitive bidding program.

Lessons Learned and Room For Improvement

We commend CMS for the way they structured the competitive bid process. The Agency appropriately provided small and medium size companies an opportunity to be a part of the program, when it would have been easier and administratively simpler for them to work exclusively with large companies. CMS also provided an opt-out clause, whereby if we were awarded the bid at a price point that we felt was unreasonable, we were not compelled to enter into a contract with Medicare. This, too, created additional burdens for CMS, but provided suppliers with flexibility and opportunity.

Likewise, we believe the use of subcontracting arrangements is well intentioned, but requires additional program oversight. If a bid winner requires assistance covering demand for product or services, they can contract with non-bid winners or sub-contractors that are Medicare Approved HMEs. This does happen and is good for the bid winners, non-bid winners, CMS,

beneficiaries and for the program's success. In some instances, however, non-bid winners are leveraging their relationship with referral sources to raise costs beyond the normal and customary amount. This impacts bid winners by increasing their operational costs.

While we can understand the rationale for sub-contracting, we do not agree that this is a positive for contract winners, CMS or the patient. Part of the rationale for entering into a competitive bid contract with CMS is the notion of exclusivity. Sub-contracting arrangements not only preclude exclusivity, but also introduces variables detrimental to the beneficiary. For example, because sub-contractors receive only a nominal setup fee and are not directly involved with the patient, they have reduced incentives to provide the best service to beneficiaries. Subcontracting is also more conducive to fraud. For example, a company that did not win a contract could function exclusively as a marketing company, obtain a referral and then provide the patient to a contract winner who would pay them the most for the referral. This puts the contract winner in an untenable position of receiving kickbacks. While CMS has tried to address the issue by requiring referrals to be made directly to the contract winner, frequently it does not function that way on the ground. Most referral sources are still unclear as to what DME competitive bidding really entails. These companies are also fed misinformation by non-contract winners. For example, many non-contract winners inform referral sources, incorrectly, that they can service Medicare patients without divulging that they do so through a contract winner.

We suggest the program should be improved in the following ways:

1. CMS should take immediate steps to inform all current and future DME suppliers and subcontractors about the rules of the road. We believe the Inspector General should issue an advisory opinion to clarify any confusion. Doing so publicly not only would enhance trust in the program, but would quickly dispel incorrect information that leads to potential overspending.

2. CMS also needs to establish a standardized process for reporting on outcomes. As mentioned above, there is little information on the correlation between services provided and patient results.

3. DME competitive bidding should not be a static program. It should evolve as new services, technologies and creative and innovative approaches evolve. We have been involved in an effort to use a technology-based disease identification, prevention and management solution to serve as a model that improves health, improves health care, and reduces healthcare costs for patients with sleep apnea that require DME product. I believe this is the next generation of DME reform: leveraging actual services to improve outcomes while lowering costs.

Conclusion

Our experience suggests that no single solution will address all the issues generated by transitioning to a competitive payment and delivery model. Does that mean we should abandon hope and revert to a failed system that encouraged inappropriate, unnecessary, overpriced, wasteful and potentially harmful care? Absolutely not.

I am also convinced that it would be a mistake to abandon competitive bidding by limiting bidders. Limiting competition encourages higher bids. While that may mean higher profits for the winning bidders, it also translates to higher cost sharing for patients. Some have suggested abandoning reimbursement based on a median price. I believe that approach is also misguided as a median pricing mechanism encourages companies to continue to negotiate price concessions and to perform more efficiently.

In the interest of taxpayers, program beneficiaries and the integrity of the competitive markets, we respectfully urge Congress to let the program continue to play out, making adjustments as needed and as outlined above.

We stand ready and willing to assist the Committee in these efforts.