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On behalf of the American Association for Homecare

Before the Subcommittee on Health

House Committee on Ways and Means

on

Medicare's Durable Medical Equipment Competitive Bidding Program

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My name is Joel Marx and I own Medical Service Company, a regional home medical equipment (HME) and respiratory care provider based in Cleveland, Ohio. Medical Service Company is a full service home medical equipment provider furnishing virtually all necessary home and respiratory medical equipment and related services to individuals through 14 locations in Ohio, Pennsylvania, New York and West Virginia. We provide home medical equipment and related services to approximately 25,000 patients annually and employ 200 associates.

Medical Service Company was founded in 1950 by my parents with one location and we have grown since then through a combination of excellent patient care and the acquisition of smaller companies that chose to sell their practices in the past few years in the face of numerous challenges. We hold all required licenses, are accredited by the Joint Commission and operate an organization-wide compliance program designed to make sure that we adhere to the increasingly complicated list of laws, rules, regulations and policies concerning the provision of HME to Medicare beneficiaries.

I would like to thank Chairman Herger, Ranking Member Stark and members of the House Ways and Means Subcommittee on Health for holding this hearing on the Medicare competitive bidding program for durable medical equipment, also known as DME or HME, for short. I am pleased to share my experience with the initial round of the Medicare competitive bidding program and make recommendations on how Congress can create a state-of-the art auction program that achieves market

pricing, is sustainable over the long term, will not reduce quality and access to home medical equipment and can be used as a model for other sectors of healthcare.

As a proud member of the American Association for Homecare (AAHomecare), I also serve as volunteer Chairman of the Board of Directors. AAHomecare is the national trade association for home medical equipment service providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of Americans who require home oxygen therapy, mobility assistive technologies (standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies.

Most of these services and products are already included or will be included in the Medicare competitive bidding program, some without any precedent for doing so. We believe that home medical equipment is a vital component of the continuum of care and is a fundamental component to controlling health care costs by keeping beneficiaries in the most cost-effective and patient preferred setting—their homes—rather than providing acute care in emergency departments and extended care institutional settings. We have grave concerns about the way in which the current bidding program is being implemented and operated.

My goal before this Subcommittee is not to argue against competition. Both the Association and I support healthy and fair competition. HME providers compete every day to provide quality health care items and services to Medicare beneficiaries and embrace the opportunity to continue to compete to serve our patients. My testimony will highlight the flaws of the current competitive bidding program and recommend a sound, budget neutral alternative—the Market Pricing Program for Home Medical Equipment—that can be implemented on the same timeline as the current bidding program.

Today—and even before competitive bidding—we are all reimbursed the exact same amount, and therefore we compete on the basis of the service and quality we offer. Ironically, the same is true in a competitive bidding market, where reimbursement is the same for all contracted providers.

However, we are opposed to the competitive bidding scheme as developed by the Centers for Medicare and Medicaid Services (CMS). The CMS program distorts the marketplace and, by ignoring the pricing methodology used in the original demonstration projects in Florida and Texas and creating restrictive governing policies of the program, goes against the original intent of Congress when it voted to implement the program in 2003. It radically reduces the number of providers (competitors), thereby creating oligopolies in the marketplace at a time when our senior population is growing rapidly. It not only allows bidders to "game" the system's pricing rules but it actually encourages such manipulation during the bidding process. And it forces providers to reduce supportive services in order to meet drastically lower reimbursement rates that were obtained through a fundamentally flawed process.

These deficiencies, which I experienced first-hand as both a contract winner and loser in this program, have been highlighted numerous times before the Congress. Meanwhile, CMS staff touts high cost savings and low negative beneficiary impact. However, the program is only running in nine markets, or six percent of the country. Providers, in the first year of a three-year fixed pricing contract, have been

able to offset excessive and arbitrary price reductions in the bid areas with revenue from non-bid areas. This will prove to be impossible in Round 2 when an additional 91 markets are involved in 2013 and beyond that when CMS applies bidding pricing in non-bid areas, including rural markets like Montana, Iowa, Kansas and even upstate rural New York, where I operate in towns that are as small as those in the Midwest.

AAHomecare does not stand alone in raising concerns with the current program. In fact, well over 200 economists, computer scientists, statisticians and auction experts from around the world have advised CMS that significant modifications need to be made to the bidding program to make it sustainable over time. Moreover, more than 30 consumer and beneficiary groups believe that the bidding program is flawed and needs to be changed.

AAHomecare has worked with auction experts to create an alternative to the current model that would give CMS a sustainable market-based pricing program for home medical equipment. This alternative preserves the concept of competition and ensures future beneficiary access.

The Association has a track record for collaborating with Congress to raise the quality standards for the HME industry and reduce truly improper payments. We have supported mandatory accreditation for providers in our industry, and we have a zero tolerance policy for fraud and abuse as illustrated by our voluntary 13-point plan and formal Code of Ethics. We have supported numerous Congressional anti-fraud efforts, including Congressman Roskam's *Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayers' Dollars Act* (FAST Act, HR 3399). To help Medicare and its contractors increase payment accuracy, we have increased our educational efforts to improve the industry's compliance with extremely complicated Medicare coverage requirements, which change frequently.

It is with this background that AAHomecare seeks again to be a partner with Congress and CMS to develop a market-based pricing program that is sustainable over the long term and which may serve as a model for other health care sectors. As Congress looks for ways to control health care spending through new and innovative delivery and payment models, I believe we have an obligation to listen to the auction experts who understand auctions best and thereby "get it right."

If we do not address the fundamental flaws in this program now, the hidden cost to beneficiaries will be exorbitant and translate into extended hospital stays, an inability to obtain services when needed in the home and unnecessary trips to the emergency department. The time to fix this program is now.

Cost Effectiveness of Homecare

HME offers an efficient and cost-effective way to allow patients to receive care they need at home. The need for HME and HME providers will continue to grow to serve the ever-increasing number of older Americans. Homecare represents a small but cost-effective portion of the more than $2.3 trillion national health expenditures (NHE) in the United States, and approximately 15.5 million Medicare beneficiaries require some type of home medical equipment annually, from rather simple bedside commodes for people who have hip replacements to high-tech ventilators for quadriplegics.

Yet, not all products are created equal: some require licensed or credentialed clinicians to be on staff or cost $15,000 just to procure. And while Congress and the Office of Inspector General have shed light on products they believe to be overpaid, many others are unprofitable for us to provide even before the bidding program. The high cost of fuel, labor, rent and utilities and regulatory compliance associated with billing and collections, HIPAA privacy, identity theft, IT security, Sarbanes-Oxley, waste disposal, beneficiary and employee safety, OSHA, DOT and FDA regulations continues to escalate year after year. Anyone who has ever required HME or had a relative who needed it can attest that our service includes much more than just the equipment.

The more that people receive quality equipment and services at home, the less that is spent on hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation's healthcare funding crisis. The facts bear this statement out as private health care plans have contracted for our services for decades and reaped the cost-savings along the way. Even the current Administration is trying to develop programs to manage chronically ill Medicare patients in the home through new demonstration projects and the Innovation Center.

One key fact that is sometimes lost in this debate is that home medical equipment represents less than two percent of annual Medicare spending. So while this program appears to reduce home medical equipment expenditures when simply comparing past and current Medicare Part B expenditures, CMS has not examined the cost shifting that occurs as a result of the program as more beneficiaries will be forced to receive care in hospitals, nursing homes, and emergency treatments. CMS is also not required to report the total cost of administering the program and yet they have hired hundreds of people and are spending tens of millions of dollars to implement Round 1, with millions more planned for future Rounds. Our alternative auction program ensures that competitive market pricing is still derived while promoting increased access, transparency, fairness and confidence in the program.

Flaws in the Competitive Bidding Program

Experts in the design and operation of market pricing programs have explained in great detail why the CMS bidding program will fail.

CMS is the only group predicting that the program is sustainable over the longer term and operating flawlessly. They are basing this on a short-lived, small sample in nine markets—a program that even CMS officials call a "pilot." Yet, Round 2, with 91 markets, is more than 10 times as complex as Round 1. AAHomecare is on the front lines and can see fundamental flaws that need to be addressed immediately. And 244 experts from across the world have weighed in identifying similar problems and have told CMS, Congress and the Administration that the program will fail. These are our main concerns:

1. **Providers' Bids Are Not Binding Commitments**

In Medicare's bidding program, bidders are not bound by the prices they bid. Any HME provider can decline to accept an offered contract from CMS after the prices, called Single Payment Amounts, are announced by the government. And because of CMS' decision about pricing, 50 percent of all bidders'

prices will be lower than their best submitted bid. Medicare's rule undermines the credibility and integrity of bids, and, without binding commitments, encourages low-ball bids from providers.

To add insult to injury, if HME providers turn down contracts, their bid prices are still included in Medicare's calculation of bid amounts, and other bidders invited to participate are forced to choose between accepting the low price which they did not influence or losing their business altogether by not participating.

CMS states that 92 percent of contract awardees accepted their contract offer. But to decline a contract would immediately imperil a provider's practice because Medicare typically represents 40-60 percent of an HME provider's revenue. Now that we are in year two of the Round 1 program, we are seeing both contracted and non-contracted providers exit the market, change their business model, close down or sell. What has propped this program up is its limited scope—it is being run in only 9 areas across the country. HME providers have been able to subsidize their competitive bidding markets with revenue from non-competitive bid areas. Yet, this cross-subsidization will evaporate as: 1) competitive bidding is expanded to 91 additional areas in 2013, 2) private payors adopt competitive bid rates, and 3) CMS applies bid pricing to non-bid areas, including all rural areas in the U.S., as early as 2015.

2. The Pricing Calculation Is Flawed

Rather than paying contracted providers the clearing price (the last-accepted bid) which is the standard in bidding and reverse auction programs, Medicare's bidding program establishes prices at the unweighted median among the winning bids, resulting in 50 percent of the winning bidders being offered a contract price less than their bids. We know of no other auction or bidding program that has such a perverse rule where bidders are offered contracts at less than the amount they submitted during the bidding process.

3. Composite Bids Are Distorted

A composite bid is an average of a bidder's bids across many products weighted by the government's estimated demand. The composite bid methodology as designed by CMS provides strong incentives to distort bids away from market prices. Only heavily weighted (based on utilization) products within a category will impact the composite bid. Providers can "game" the system by bidding very little off the current Medicare allowable for certain products with little weight while bidding more aggressively on other items with a higher weight. This creates a program where individual products are not closely related to costs and providers participating in the program can "game" the system in order to manipulate the single payment amount. In addition, Medicare set a maximum for all items bid—again distorting the bidding process by not permitting bidders to fairly bid based on their true, fully-loaded costs.

4. Lack of Transparency

CMS has shared virtually no data with the public on the selection of contracted providers, calculation of historical demand (capacity), calculation of the single payment amount for products and services

covered by bidding and outcomes-related findings to evaluate the program. Instead, CMS has made generalized statements that point to the so-called success of the program. Even the Agency's first year update after the implementation of the program is based on generalizations with little data to back up its findings.

Moreover, the savings numbers recently quoted by CMS appear to "double-count" savings resulting from anti-fraud and abuse initiatives that were implemented concomitantly with this program. For example, new provider screening tools, real-time claims monitoring and an avalanche of incremental pre- and post-payment audit activity have been implemented since the program began in 2011. It is surprising and shocking to us that Medicare has elected to audit contract winners in Round One markets so heavily when, in fact, CMS has stated that the program should, on a stand-alone basis, root out fraud and abuse. If this is the case, why deluge contract winners with thousands of audits when those precious resources might be applied to other high-risk healthcare segments and markets?

Under the current program, pricing can be easily manipulated through subjective adjustments to the capacity that a provider lists on its bid forms. During the announcement of the Round One Rebid pricing a CMS official stated the following about contract winners' financial stability. During a press call on July 2, 2010, the CMS official stated –

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

This fact calls into question the validity of the payment rates established by the program and the supposed objective process that CMS established for the program and published in its original Final Rule. The above public comment confirms that CMS may adjust a provider's stated capacity if it questions the provider's bid because it was considered low. By adjusting capacity, CMS manipulated the single payment amount and subjectively decided how many winners were needed. This is completely counter to the more quantifiable rules CMS published initially for the program. The bidding program then just becomes another way to apply administered pricing rather than letting the market set reimbursement rates. The subjectivity is playing with the very viability of numerous family-owned businesses across the country.

5. The Bidding Program Is Designed to Be "Gamed"

Due to the methodology concerning how payment rates are calculated, the impact of non-binding bids and the ability to manipulate the capacity that a provider self reports, the program is built to be "gamed." CMS even appears to acknowledge this fact in its first annual report on the bidding program when they state that, "we are strengthening our bona fide bid review process…to check that very low

bids are sustainable by checking more of those bids." Questioning the sustainability of very low bids implicitly brings into question a program where the single payment amount offered by CMS is, by definition, lower than 50 percent of the accepted bids presented. If the bid amounts represent the lowest pricing while maintaining quality service, how can a program that reduces the pricing additionally be sustainable over the long term?

Under a "win at any cost" program, providers would do well to submit an unreasonably low bid—"a suicide bid"— in order to win a contract. These providers then would be assured of a contract but they must hope that other providers bid more rationally so that the single payment amount would be higher than their submitted bid. From here, providers facing low reimbursement rates could agree to furnish competitively bid items but subsidize their revenue from non-Medicare or non-competitive bidding patients. CMS has never shared with the public how many of the 356 original contract providers have sold their businesses, gone out of business or simply did not bill Medicare for competitively bid items. This is a critical question for Congress to consider, because there were 6,922 unique HME providers submitting claims/providing services in 2010 in the nine bidding areas.

6. CMS Monitoring Is Weak and Non-Transparent

When the bidding program was first implemented, CMS required HME providers to provide the exact brand and model of equipment they were providing to Medicare beneficiaries. CMS also stated that it would begin to measure the patient satisfaction of beneficiaries who received HME services. This equipment report was intended to allow the Agency to determine if contracted providers began to substitute lower quality equipment under the program than was previously furnished to beneficiaries. However, CMS modified this requirement after one quarter into the pilot so there is no way to monitor the quality of equipment Medicare beneficiaries are receiving. And to date, we have seen no beneficiary satisfaction data whatsoever, despite the program's 16-month implementation.

7. No Due Process

Currently, there are no due process protections or appeals processes in place for providers to appeal CMS' methodology for establishing payment rates, making contract awards, designating bidding areas, deciding on the phased-in implementation approach, selecting items and services or the bidding structure and number of contractors. Numerous companies were initially qualified due to a technical error on CMS' fault, and yet it took over 120 days to resolve the issue—a date past the implementation date of 1/1/11.

Fixing the Bidding Program

Congress's objective in requiring Medicare to use a competitive bidding model to establish payment amounts for HME was to reduce Medicare expenditures and ensure that beneficiaries have access to quality items and service. This objective cannot be met because CMS has designed a program that does not hold bidders accountable, does not ensure that bidders are qualified or capable to provide the products in the bid markets, and, due to the arbitrary nature of the capacity analysis, has produced bid rates that are financially unsustainable.

As I mentioned previously, auction experts and economists have warned that the Medicare bidding program is unsustainable in its current form. It will create significant barriers to access and will destroy the HME infrastructure that seniors and people with disabilities depend on as the program expands and providers cannot offset bid pricing with non-bid revenue.

Unfortunately, the recommendations of auction experts, beneficiary and consumer groups, the Medicare Program Advisory and Oversight Committee (PAOC)—the panel created by Congress to advise CMS on the design and implementation of the program—and AAHomecare and other interested groups have not been acted upon. We now look to Congress to fix systemic problems so that Congressional intent is followed.

To fix the fundamental flaws in the bidding program, an alternative market-based pricing program for HME has been developed, which has been specifically tailored to the HME marketplace. The proposal, known as the Market Pricing Program (MPP), would require changes to ensure a financially sustainable program. The MPP uses an electronic state-of-the-art reverse auction to establish market-based reimbursement rates for HME around the country. These changes are consistent with Congress' original intent: to create a program that is based on competition while maintaining beneficiary access to quality items and services. The MPP would be implemented on the same timetable and apply to the same DME product categories as the current program, and will reduce government spending for DME items nationwide. It is intended to be budget-neutral.

The following are key features of the MPP:

1. Timeline

The MPP would be effective on July 1, 2013. The design of the program would be developed through a collaborative, transparent process, involving all stakeholders (HME providers, CMS, beneficiaries), with the guidance of an auction expert and the oversight of the market monitor, to establish market rules, to set market-based and sustainable reimbursement rates, and protect beneficiary access to, and choice, of quality HME products, services, and supplies. The use of an auction expert to help the Secretary of the Department of Health and Human Services design the auction program and a market monitor to help the Secretary ensure that the program is operating effectively and efficiently are common among public auctions.

2. Auction Operation

The MPP would auction a representative 20 percent of the market (counties eligible for bidding) with two-year contracts. The remaining market areas eligible for the program would be served by any eligible providers furnishing HME at the reimbursement rates determined by the auction. The reimbursement rate established through the auction would apply to similar geographic areas (i.e., urban to urban, suburban to suburban) and be adjusted for regional characteristics.

Each year thereafter, the MPP would auction a representative 10 percent of the market (counties eligible for bidding) with two-year contracts starting on July 1 of the year of auction.

An additional 10 percent of eligible market areas would be subject to auction each subsequent year until market pricing programs are occurring in 100 percent of eligible market areas throughout the United States. The process would continue and the Secretary, in consultation with the auction expert, would continue to select additional eligible market areas on an ongoing and rotating basis. **This design would create the most accurate competitive market payment methodology in the Medicare program.**

3. Market Areas

Market Areas established by the Secretary would be composed of a county, an aggregation of counties or parts of counties that together form an economically interdependent area. Large counties would be permitted to be subdivided. The current program's geographic areas are too large to be effective because not all HME providers are able to service an entire area. Smaller contract winners need to subcontract to serve large MSAs and lose quality control since another provider is furnishing the prescribed equipment and related services.

4. Rural Exemption

The same areas that are exempted under the competitive bidding program would be exempted by the MPP.

5. Transparent Process Required

In establishing the MPP, the Secretary would utilize an open and transparent process that includes all relevant stakeholders in the market. Provider and beneficiary education would be required in consultation with the auction expert and market monitor.

6. Market Design

The Secretary would conduct an auction beginning no later than March 2013 and ensure that the market has these basic features:

In each market area, two product categories would be auctioned, producing the clearing price and limiting supplying rights to bid winners. The "lead product" would be submitted for bid in the auction.

Bidders must provide a cash deposit or irrevocable letter of credit (LOC) (from a qualified institution) of 10 percent of expected annual volume as a bid guarantee and winning bidders must provide same as a performance guarantee. Winning bidders must accept a contract (binding bid).

For each product category, a "lead product" is determined by the auction expert on the basis of cost and utilization. Only the "lead product" is bid. The "lead product" sets the pricing for the category and the pricing of all other products in the product category is set relative to the "lead product". The "lead product" is the baseline pricing for the category, and establishes the clearing price. The auction expert will aggregate the various price weighting percentages reported for each product to adopt a single capacity-weighted average. This relative price index will be publicly disclosed in advance of the auction so that each bidder will know how each product price will be determined in the auction.

In the market area subject to the auction, the reimbursement rates of the other "non-lead products" subject to the MPP would be established by reference to reimbursement rates established in economically similar areas in which that product category was subject to auction and all qualified providers able to accept that price would have the right to provide products and related services.

The MPP would use the market "clearing price" (the first excluded bid in each product area) for each product area.

HME providers whose bid is below the "clearing price" would be offered a contract for a two-year period. HME providers whose bids are below the clearing price must accept the contract.

Conclusion

Auction experts have spent more than a year developing changes to improve the current bidding program. AAHomecare stands by and supports the design of the MPP. We strongly urge this Subcommittee and Congress to support this program to establish market pricing for home medical equipment. AAHomecare urges the Subcommittee to secure a cost estimate for the Market Pricing Program and to pass legislation that would change the current, flawed bidding system to a sustainable market pricing program at the earliest legislative opportunity.