TESTIMONY IS EMBARGOED UNTIL 9:00 AM WEDNESDAY MAY 9, 2012

Testimony of H. Wayne Sale, Chairman
National Associational of Independent Medical Equipment Suppliers
On behalf of its Members
Before the
House Ways & Means Subcommittee on Health
May 9, 2012 @ 9:00 am

Chairman Herger, Ranking Member Stark, members of the Committee, my name is Wayne Sale, and I am the Chairman of the National Association of Independent Medical Equipment Suppliers (NAIMES). I hail from Virginia's 7th District where Patrick Henry gave his "Liberty or Death" speech, Jefferson built his state house and Chief Justice John Marshall called home. I have been active in this industry for 35 years as a respiratory therapy practitioner and business owner. I currently have a DME and Oxygen business in Central Virginia and employ 30 great people. NAIMES is a volunteer trade association that represents the specific concerns of community based, independent medical equipment suppliers. Our member demographics comprise 96% of the currently active Medicare DMEPOS suppliers, 90% of whom are threatened by this purported Competitive Bidding process.

It is important to begin my comments at the highest level of our country's domestic national concern – the ever-rising costs of healthcare. As medical inflation races ahead of the economy and accounts for higher and higher portions of GDP, we earnestly seek ways to slow its growth and manage our costs. This problem has haunted the budgets and politics of every President and Congress since Medicare's inception. When this hearing concludes, I hope you will leave with a better understanding of how DMEPOS suppliers can contribute to the reduction of those costs.

History

In an effort to curb the costs of Medicare expenditures in 2003, Congress directed CMS, through the Medicare Modernization Act, to employ a formal Competitive Bidding process in order to "reset" Medicare reimbursements for DMEPOS products to achieve "market-based efficiency". This sector of Medicare spending consistently comprised about 2% of the monies annually disbursed. In 2008, the Medicare Improvements and Patient Protection Act (MIPPA) amended CMS's directions for program development slightly, but did nothing to substantially amend the pseudo competitive bidding process that CMS created and controlled behind a veil of secrecy allowed them in 42 USC 1395 w-3(b)(10), the elimination of a program participant's right to an administrative or judicial review.

On February 11, 2009, the DME industry's testimony before the House Small Business Sub-Committee on Rural and Urban Entrepreneurship, pointed out the detrimental effects and unintended consequences of the CMS designed bidding process, and urged the Committee to intervene before re-starting the stalled initial rollout. The industry, patient and expert testimony was not enough to stop the program from being reinstated and on January 1, 2011, CMS's version of pseudo-Competitive Bidding went into effect in 9 Competitive Bidding Areas (CBA's). (Cleveland, OH - Charlotte, NC – Cincinnati, OH – Dallas/Fort Worth, TX – Kansas City, MO/KA – Orlando, FL – Miami/Fort Lauderdale/Palm Beach, FL – Pittsburgh, PA and Riverside/ San Bernardino, CA)

The "competition" that Congress planned to achieve was supposed to occur as suppliers offered the CMS prices at which they could sell the defined products, make a profit, and maintain service to their Medicare patient population. The CMS process of supplier contractor selection, side stepped the "competition" requirement as their program design accepted bids that were non-binding and used the collection of bids offered to choose the price they would assign the product. Apparently, that looked like "competition" to the creators, but in fact, was just another form of administrative price assignment. These contradictions to a genuine competitive bidding process were revealed by several economists, who looked closely at the bidding process created by CMS. Their findings of the program's serious shortcomings were bought to the Congress's attention and CMS leadership directly. Failing to generate sufficient interest to bring the needed change to the program, they thought it imperative to submit their findings and concerns to President Obama in a letter dated June 17, 2011.

Since the commencement of the pseudo-CB in these 9 CBA's, 90% of the suppliers have been removed from the Medicare marketplace, leaving fewer suppliers to service the growing population of Medicare beneficiaries. The elimination of suppliers, combined with the program's forced enlargement of service territories in every CBA, has unquestionably caused distress in the healthcare continuum in the affected areas. Reports of stalled hospital discharges, delays in equipment delivery, and slower response to the delivery of physician ordered equipment have been reported. Suppliers who were not chosen to participate in the contracting process have experienced obvious decreases in referrals and revenues, and subsequently had to lay off workers; an estimated 40% have gone out of business.

While CMS boasts that the savings are mounting from the effects of this program, there are reports generated from FOIA data requests that indicate those savings are being quickly spent at more expensive treatment sites - emergency rooms, hospitals and skilled nursing facilities. These findings have, again, been openly shared with CMS leadership, in an effort to **discern the truth** of how this program is performing at the Medicare beneficiary level. CMS has merely ignored the findings, dismissing them on technical grounds instead of addressing the issues they raise. This conflict of data interpretation is a key point that must be resolved if Congress is to be satisfied with the manner in which CMS has carried out its directives.

The fact that 244 economists from America's most prestigious colleges and universities have examined the CMS bidding design and found it wanting, is not insignificant. (Some of these economists are your constituents) This is NOT a consensus among economists – it is unanimous. Four of the examiners are uncompensated, unbiased Nobel Laureates. Their standards for a successful competitive bidding/auction program design are derived from years of study, scientific trial & error, and market experience around the globe. It is concerning and telling that their knowledge and feedback have been ignored and repelled by CMS for reasons yet to be revealed.

A concern voiced by my membership that exposes a hidden consequence of the CMS design is the fact that some companies that DID get contracts are NOT getting business. The patient referral community – case managers and social workers – have learned that some suppliers were offered contracts for multiple equipment categories and are calling them only, to avoid the time consuming complexity of calling multiple companies to arrange multiple deliveries to establish an adequate treatment site at the patient's home. This effectively eliminates "winning bidders" from the marketplace who accepted a single product contract, reducing the access, choice and service for Medicare beneficiaries, even further.

The most distressing news in the forecast of Competitive Bidding's future is that of the program's unsustainability. There is a high degree of confidence from all parties that the program's design will ultimately lead to failure in the marketplace. Such an aberrant program design has never before been tried or tested. The absence of binding bids, and the assignment of the median bid as the final price, invites foundational weaknesses in the program from the very beginning. The low number of available contracts, and high probability that you won't be offered one, incents bidders to low ball their bid in a desperate act of continuing to participate in the largest insurance program in the world – Medicare.

If the economists are correct and the CMS program design is not sustainable, then neither is the billions of dollars of savings they claim their program will generate. For this reason, it seems realistic to believe that the CMS projected savings are overstated.

The only defense that CMS offers for continuing their version of pseudo-CB is the absence of a significant number of complaints from Medicare beneficiaries. It is clear to my members that there are indeed problems, complaints and concerns. The primary complaint we hear is that people who call the Medicare Hotline to complain, stay on hold for unreasonable lengths of time and eventually give up on registering their complaint. Another reason complaints may not to be heard is that the effected Medicare beneficiary is sick, and tired, and simply doesn't have the energy to go through the process of questioning and explaining and waiting. It's easier and less stressful to find another way to deal with their particular issue than to waste time on the phone.

Round 2 – What's next?

NAIMES leadership has met with CMS management and urged their reassessment of the CB program. Our discussions have been direct and clear as to the predictable outcomes voiced by the auction authorities and the dictates of the rules of market economics. The information submitted to CMS during those discussions, although compelling, have made no impact on CMS's position. It has been clearly stated by CMS representatives that it is determined to carry out Round 2 in similar fashion as Round 1 and looks forward to similar results. That means in 91 US cities, another 90% of the community based DMEPOS suppliers will be eliminated from the Medicare program. As the number of business failures and worker layoffs increase, the number of Medicare beneficiaries will grow almost exponentially. Every day for the next 30 years, approximately 7000 Americans will turn 65 and enter the Medicare system; 78 million, in all.

So, why is CMS intentionally reducing suppliers in the face of rising demand?

With fewer suppliers, and more consumers, how does CMS expect prices to stay low? Laws of economics have soundly established that in a dynamic marketplace, competition among many suppliers keeps prices low, service high, and innovation moving forward. The people who know, say the CMS design will result in higher prices over a short time. In market growth such as the one America will experience in the next 3 decades, a preferred executive plan would be to grow and develop the supplier population to meet the demand. The Baby Boomer demographic has changed every market it has aged through over the last 50 years and those dynamic changes are beginning to trickle into the healthcare industry now.

Over the first 3 years that this version of pseudo-CB is in place, the forced reduction of the supplier population and the increase in market demand promises to raise prices, and again, reduce the CMS projected savings. Said in a more familiar manner, healthcare costs will continue to rise.

If, for all the reasons above, Congress does not stop the implementation of Round 2, we have no reason to believe the findings and ills of Round 1 will not be multiplied by 10. Expanding a poorly designed bidding program will expand the destructive results of that poorly designed bidding program. If we go forward into 100 US cities, perhaps then the volume of beneficiary complaints will be high enough and loud enough for Washington to hear and be moved to act. But, will it then be too late?

Changes are necessary, and sooner is better than later

In order to avert the negative impact and consequences of the current version of pseudo-Competitive Bidding and secure the Medicare DMEPOS benefit sustainability, changes are necessary.

Historic data of Medicare expenditures reveal that, unlike every other category of Medicare spending, Medicare Part B spending in the DMEPOS categories has been practically flat over the last 20 years. Although the industry has experienced an increase in utilization and in the costs of doing business (salaries, gas and employee benefits), US expenditures are consistently less than 2% of the per annum spending. The forced elimination of 1000's of small businesses across the nation from a federally funded program is unimaginable, but that is currently the promise of the future.

NAIMES, in cooperation with a coalition of industry associations, manufacturers and auction experts, have taken a properly designed auction format and created a replacement auction design we have named the "Market Pricing Program" (MPP). An earlier version of this bidding process was tested in a "mock auction" at a trial site on the campus of the University of Maryland in April of 2011. The trial engaged 100 suppliers and a wide variety of associated participants who learned, navigated and" bided" on a list of DMEPOS products, pulled from those used in Round 1. I was in attendance. At the end of the day, the results showed that the mock auction, conducted in the sunshine of transparency, resulted in lower prices for the payer, sustainable market prices for the seller, and market demand being met by a large number of willing participants. Initially, the industry eyed the process with skepticism, but saw that day, that it was a healthy alternative to the pseudo-competitive bidding process imposed by CMS. CMS, CBO and other government agencies was there also and invited to participate. Records of the mock auction are online at http://www.cramton.umd.edu/papers/health-care/

The MPP speaks directly to the short-comings of the current version of non-competitive bidding. Its creators are experts in auction design and, like any good architect, they have followed the known rules of market forces to build a system that will last. The MPP version employs binding bids, performance obligation and national accreditation to assure that suppliers bid to win, make a profit, and stay in business for years to come. The MPP reduces the enormous consumption of time that the current regulatory process requires, and promises to save millions in administrative costs. MPP reduces the geographic size of the CBA's, making them more conducive to prompt service and delivery. And best of all, it achieves sustainable savings and patient choice from a large supplier population ready to meet the growing future demand. Mechanisms have been built into the process that will assure the government gets the best competitive prices, offered by experienced suppliers, willing and able to meet the capacity in their service area. This plan sets the stage for healthy growth in an industry that has proven it can contribute much to the reduction of Medicare spending, particularly in the areas of chronic disease maintenance and prevention of expensive exacerbations.

Since building and launching the MPP is a much less burdensome and time consuming process, the belief is that it could be built in more quickly than the current Round 2 process and be ready to engage the market on a very similar timeline as is currently scheduled. But we must admit, time is of the essence.

What this change would mean to Congress is that the DMEPOS provision of the Medicare Program will be truly competitive, it will save money by enabling patients to be treated at home, avoiding expensive hospital stays, and will cost the Administration less to implement and maintain.

Conclusion

Congress should move to suspend or repeal the current program. If one believes the experts in auction design, and accepts the premise that it could be made better, then a replacement program should be vetted, secured and deployed.

The warnings that the current version of Competitive Bidding will ultimately fail should be taken seriously. The drastic reduction of "supply" in the face of unprecedented national "demand" for home health products and services will bring irreparable harm to the industry and the Medicare population they serve. The sustained concerns voiced and high integrity of testimony is compelling, and should be heeded.

The DME industry takes seriously its personal responsibility to ensure that our nation's seniors have proper access to medically needed, physician prescribed care. We take seriously the opportunity we have to reduce the costs of healthcare to our nation. Both objectives demand that seniors with chronic disease have the DME equipment they need to maintain their health and independence. Utilization of DMEPOS is the most cost effective manner in which to avoid the high cost of hospitalizations incurred by those few chronically diseased patients who consume the most expensive and largest volume of healthcare services. The DME industry brings real, measurable Value to the Medicare Program. Studies and Medicare claims data analysis show savings expressed in terms of Return on Investment to be $6-$10 for every $1 spent. Reductions in ER visits, reductions in hospital stays and reductions in the use of skilled nursing facilities fund the savings and ROI calculated here. That's the Value of the DME benefit to the Medicare Program. If the net savings (ROI) from avoiding the highest priced healthcare services is only $6: $1, the annual total savings that DMEPOS brought to the Medicare

program last year alone is $40 billion – $400,000 billion over 10 years. That's the savings the DMEPOS program achieves by preventing chronic disease from overpowering its host. That's the powerful effect of reducing healthcare expenditures by focusing on disease management, rather than budget management. We must refocus our attentions on the reasons for the high costs of healthcare, and prevent the need to spend at more expensive treatment sites.

In June, 2011, realizing the savings that could be achieved by employing a policy of Prevention, President Obama ordained a National Prevention Strategy, headed by the Surgeon General and signed off on by his entire Cabinet. That Strategy employs the common sense tactics of community based care for chronic diseases as one of its goals because of the obvious savings it will generate. *An ounce of Prevention is worth a pound of cure*. This Strategy is a perfect example of how CMS could and should use its influence and resources to attain higher levels of efficiency using the home health services, equipment and supplies sectors.

Additionally, the Innovation Center of CMS has just released 16 pilot grants under a program called "Independence At Home" which specifically targets COPD and CHF patients with the intention of saving large chunks Part A dollars by using small pieces of Part B dollars. It is a sound program, launched with great anticipation and a focus on chronic disease management to accomplish large savings.

If you include the Hospice and Palliative Care programs as programs installed by CMS that save Medicare by avoiding expensive hospital stays for those with terminally illnesses, then you understand how the hospital beds and oxygen and other durable medical equipment are indispensable tools to accomplish those savings.

Given the Administration's propensity towards Prevention and the obvious savings this strategy already brings to other areas of Medicare spending, there is a golden opportunity, and fiscal imperative, that can be joined together to put the DMEPOS benefit in full competitive gear, and lay the foundation for our country the achieve a more cost effective future.

Recommendations & Requests

We recommend that Congress repeal the current version of the Competitive Bidding Program and replace it with the truly competitive Market Pricing Program.

If further evaluation is necessary before you act, we request that you help facilitate a fuller understanding of the impact of Round 1 by requiring CMS to submit to you the "before and after" 1/1/11 utilization data from the same CBA, as opposed to comparable populations in similar cities that they report now.

If further evaluation is needed, we request that you require CMS to reconcile the differences in their Round 1 data analysis results and the industry's Round 1 data analysis results through FOIA requests. The true effects of this program must be known before expanding it into 91 additional CBAs.

On behalf of Medicare beneficiaries who have complained to us, we request that you require CMS to design and employ a Medicare Help Line that is more efficient and responsive to the needs of our growing Medicare population.