



The Pennsylvania Association of Medical Suppliers

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**Testimony of
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Before the
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Committee on Small Business
Subcommittee on Investigations and Oversight
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Mr. Chairman and Honorable Members of the U.S. House of Representatives Committee on Small Business Subcommittee on Investigations and Oversight, my name is John Shirvinsky and I am the executive director of the Pennsylvania Association of Medical Suppliers (PAMS). PAMS is America's oldest state advocacy organization representing the interests of home medical equipment (HME) providers.

About PAMS and the Promise of HME

PAMS' membership is comprised of companies that supply durable medical equipment and supplies to the public. The companies we represent are overwhelmingly small and independently owned. Our members are in the business of helping people with serious health conditions live comfortable lives in their own homes. In doing this, our members help the health system save substantial dollars.

In addition to our role as advocate, PAMS provides the forum and the opportunity for our members to receive educational programming, to promote ethical standards of practice for the HME industry in our state, and to foster the highest standards of care for the people in need of home medical equipment and supplies.

You might ask how it is that our members manage to introduce savings to an ever-more-expensive health system. The answer is that we are a low-cost alternative to some of the most expensive forms of health care, such as long-term care and hospitalization.

In Pennsylvania alone, the cost to the state's Medical Assistance (Medicaid) system to place a single individual in a long-term care facility runs an average of about \$56,000 per year. In comparison, it costs about \$23,000 per year to give that person the same level of care in their own homes.

But the savings potential of HME providers doesn't end as an alternative to long-term care facilities. People with long-term respiratory problems, such as COPD, can receive home treatment for an entire year for less than the cost of a single day's visit to the hospital. That's an average of about \$6.65 per day for in-home oxygen care vs. a

national average in excess of \$4,600 per day for a hospital stay. Our home infusion therapy providers offer a variety of life-sustaining intravenous medications, including chemotherapy, which are far more cost-effective than the alternatives of in-patient or out-patient treatments. The average cost per day of home therapy was \$122, compared to \$798 in the hospital and \$541 in a skilled nursing facility setting.

I would respectfully urge you to remember these numbers as you and your colleagues search for ways to find savings in the Medicare and Medicaid systems. Our industry, in conjunction with home healthcare professionals, can provide individual, in-home care for roughly 40 percent of the cost of long-term institutionalization. I challenge you to find another healthcare sector that is capable of making a similar claim. And who wouldn't want to remain in their own home given the choice?

Competitive Bidding and the Small Provider

We first commend this Subcommittee for taking this opportunity to examine the impact of CMS's competitive bidding program for DME and for looking at the question, "Will small suppliers be able to compete?" That is a question that many of us have been attempting to contend with for much of this year. The question might as well be, "Will small suppliers be able to survive?" One small provider in Pittsburgh – who does about 65 percent of his business with Medicare – recently told me that this is a question that keeps him awake at night.

It is important to recognize that phrasing the question in those terms is not hyperbole. It is a sober recognition of what the competitive bidding process is and who the majority of DME providers are. Competitive bidding generally – and particularly the competitive bidding process that has been applied to DME – is an exclusionary process. It is a process that produces winners and losers; and it produces far more losers than winners. It has been one of the stated goals of the Centers for Medicare and Medicaid Services (CMS) to reduce the number of DME providers serving Medicare beneficiaries.

The HME industry is not populated by big players who have cornered the market. It is a healthy market sector that is largely made up of small, independently owned providers serving relatively small service areas. Yes, there are a number of large national and regional providers, but they are competitors and do not tend to dominate markets.

Therefore, since competitive bidding is an exclusionary process, and since the majority of providers tend to be small and independently owned, it would stand to reason that the losers – those who will find themselves precluded from further participation in meeting the DME needs of Medicare recipients – will be small, independently owned companies.

To understand how CMS structured its small provider provisions, let's refer to a CMS press release from April of 2007 describing the program:

“The final rule provides for a 30 percent target number for small supplier participation. If CMS determines after the initial evaluation of bids that there are not enough small suppliers with winning bids to meet the target goal of 30 percent in each product category, then contracts will be offered to small suppliers that submitted bids higher than bu(t) close to the winning bids. The small suppliers will have the option to accept the single payment amounts based on the winning bids until the 30 percent goal is met or there are no additional small suppliers.

“The final rule also allows small suppliers to form networks in order to participate in the bidding process, provided that these networks comply with all federal and state laws including the federal antitrust laws. In addition, small suppliers will not be required to submit bids for all product categories. As a result, small suppliers will have the flexibility of deciding for which product categories to submit bids.”

So, CMS set a “30 percent target number for small bidder participation” *if*:

- The small providers are able to meet the CMS-established qualifications for bidding; and if
- The small providers are able to demonstrate the ability to serve an entire metropolitan area even if their existing business is limited to a small portion of that area; and if
- The small providers are willing to accept a bid price lower than the one they submitted; and if
- The small supplier’s bid was “close” to the winning bid.

It’s hard to feel terribly secure if you are the one facing all of those “ifs.” The bottom line is that CMS will try to give some market share to small providers so long as small providers are available and able to do the job for a three-year fixed price. Employment costs may not be fixed; gas prices may not be fixed; health care expenses may not be fixed; but Medicare reimbursement rates will remain fixed for three full years.

Finally, CMS set forth the possibility of small providers participating in small supplier networks for the purpose of submitting bids. This is as good of an illustration as any as to how little the folks at CMS understand about the DME industry or business in general. I’ll quote the press release again: *“provided that these networks comply with all federal and state laws including the federal antitrust laws.”* So the challenge here was for several small DME providers to gather together for the purpose of submitting a combined bid at agreed-upon prices and to somehow not violate federal or state antitrust laws in the process. In other words, they needed to find a way to agree upon pricing without actually discussing or fixing prices. That’s a neat trick if you can pull it off.

To the best of my knowledge, no small providers were able to successfully form such a network in the Pittsburgh competitive bidding area. In my conversations with other state associations and the American Association for Homecare, no such networks

were reported to have been formed anywhere in the country. I am confident about my information on the Pittsburgh MSA.

What small providers did do in Pittsburgh was to take the initiative to form *ad hoc* subcontracting arrangements. There was no practical way to structure a network as envisioned by CMS because there was simply too much to overcome, even if antitrust were not a consideration: the ability to rely on the performance of others not under your direct influence; the attorney fees involved in creating a network; the inability to agree on structure; different standards on things ranging from employee compensation to service standards to hours of operation.

The subcontracting arrangements were another example of necessity being the mother of invention. Faced with extinction and unable to utilize CMS' flawed networking scheme, these companies decided to take advantage of the program allowance for subcontracting arrangements to meet the needs of the request for bids (RFB). Each provider agreed that they would submit their own bids and secured letters of intent from one another to provide products and services throughout the Pittsburgh competitive bidding area.

You might say that that was a clever idea and you'd be right. But you should also wonder why it is that honest, hard-working business people need to come up with clever ideas in order to survive as providers of such important equipment and services to Americans in need.

Problems with Competitive Bidding

Competitive bidding was a bad idea from the get-go. It was inserted into the Medicare Modernization Act of 2003 in the middle of the night just prior to final passage. It was not properly vetted. It was not properly thought through. It makes pretensions about its ability to save money (on a very, very small portion of Medicare spending) that are simply unsupported and unsustainable. It makes no account for its impact on businesses, communities, employment, product quality, quality of care or the potential for increased hospitalizations in the Medicare population that may result. It is a program that promotes the concentration of market share yet takes no notice of the inherent dangers in such concentration. Competitive bidding is a bad idea.

The CMS competitive bidding process received failing grades from Pittsburgh area providers of all types and sizes. From the many providers with whom I have spoken, it has been called flawed, ridiculous, unworkable, overwhelming, frustrating, crazy, uninformed, anti-private enterprise, absurd, disturbing and misdirected.

Prior to and during the bidding process, I fielded numerous calls from small DME providers seeking insights into the monstrosity that CMS had unleashed. The process is big, it is complicated, and it is intimidating. More than one questioned whether the time had come to close their doors. Should they finally retire? Should they find another business or seek other employment opportunities?

One of the more common complaints is that CMS simply doesn't understand the DME industry, what it is that we do, the vast array of patient services that we normally provide, and the nature of our operations.

DME is overwhelmingly a network of small to medium-sized businesses serving relatively small service areas. The planners at CMS may look at the Pittsburgh MSA as a small, homogeneous metropolitan area, but they are wrong. Most living in those areas shown on the CMS Pittsburgh Competitive Bidding Area (CBA) map (see Attachment A) may agree on their love for the Steelers, but western Pennsylvania is a quilt work of neighborhoods, communities and counties that have little to do with the city of Pittsburgh other than as a point of reference.

The Pittsburgh CBA is big. It incorporates the seven counties directly surrounding Pittsburgh and tiny bits and pieces of another seven counties. The northern reaches of the CBA have little to do with the southern. The eastern reaches have little to do with the western.

Congressman Altmire's 4th Congressional District serves as a good reference point. It forms the northwest boundary of the MCS map, shoots east across the middle of the CBA and ends in Murrysville to the east. Few Murrysville residents are inclined to do their shopping or look for medical care in Cranberry. Fewer still would be interested in traveling to Beaver Falls. While Congressman Altmire represents the interests of all of these communities, his constituents in those communities have precious little interaction with one another. Of course, CMS is seeking to change that for individuals in need of DME products and services.

Small DME providers normally serve relatively small service territories. They are unlikely to serve an entire MSA of the likes that we are talking about here. Mandating such extensive coverage, as CMS' competitive bidding does, serves as a barrier to entry. This is particularly true for those companies that may operate on the boundaries of the CBA. I recently spoke with a provider located in Cambria County (not in the CBA) who does a significant amount of business in neighboring Westmoreland County (in the CBA). He had been hoping to expand his operations further westward to eastern Allegheny County. But the competitive bidding process was far too high a hurdle for a small provider on the fringes of the CBA to surmount, so he chose not to bid. His services will soon no longer be an option for his Westmoreland County patients.

So it is easy to see in this example how the DME competitive bidding process can stop a company from growing. But it is also restricting patient choice by eliminating competitors from the marketplace. And once you eliminate competition, the stage is set for service to suffer. The few competitors who remain will be hard-pressed to remain financially viable under the initial contract terms and something will have to give. As operating costs continue to increase and margins fall, service becomes a likely target for cutbacks.

The problems experienced by first-round bidders with the CMS computer system have been well documented and don't warrant any further comment from me other than to say that they were real and added significantly to the time and cost of bidding.

Other problems identified by bidders within the Pittsburgh CBA were:

- The process was convoluted and required companies to bid on items and services even if these are not items that the provider normally deals in. A prime example of this is oxygen. Medicare reimburses for oxygen at a single rate even though the acquisition and labor costs vary greatly among the different types of oxygen systems. Because liquid oxygen has the highest costs associated with it, many providers got out of the liquid oxygen business many years ago. But in order to qualify to bid for any oxygen, you had to bid for all oxygen. This was a hurdle for many companies.
- Competitive bidding is certain to create frustration for beneficiaries. Today a beneficiary is likely to have a single provider serving all of their DME needs whether it be mobility, respiratory or hospital beds. Under the CMS plan, a sick, elderly person may need to deal with a different company for each need depending on how the bids are awarded. In the event of an emergency, this may prove catastrophic should the individual be unable to remember which provider supplies which service. If this program results in an increase in emergency room visits or increased hospitalizations, it is not likely to save any money at all.
- The inclusion of complex rehab may rank as the single most inappropriate provision in the DME competitive bidding program. It is called complex rehab for a reason – it is complex. When a healthy teenager is suddenly rendered quadriplegic due to a severed spinal column from a violent automobile accident, it is a life sentence. It has been the policy of our nation to give such young Americans a chance at life. A chance at continuing with their education, a chance at a career, a chance at having a family and a home. A number of federal initiatives, including the Americans with Disabilities Act and the New Freedom Initiative, seek to ensure that people with disabilities face no further obstacles to full participation in our economy and society. But for such individuals, that chance starts with getting fitted for a power wheelchair that will be their means of mobility for the rest of their lives. It is not a simple process. Each case is different. The size of the chair differs; the seating components differ; the means of steering and moving the chair differs; and the process of acclimating the individual person to the individual chair differs. It makes absolutely no sense to attempt to place such a necessarily individualized process into a one-size-fits-all box. It is precisely because this is high-priced equipment that great care should be taken to get it right the first time. Attempting to force DME providers to supply such complex and individualized equipment “on the cheap” will likely cost more money in the long run.

- Although it is hard to say whether the small business set aside will prove successful or not, it is easy to note that the minority set-aside will not bear fruit. There was no provision made for minority or women-owned enterprises.
- No one seems to have a high confidence level in whether they complied with all program provisions or not. The financial requirements were unclear as were various other program elements such as the definition of capacity.
- Finally, our members are unsure about who it is that they are competing against. Since anyone is free to bid in any CBA, some very large concerns are said to have submitted bids in every CBA, even those in which they have no current operations. Since they had already done the work of preparing bids elsewhere, why not simply submit bids everywhere? That may turn out to be a good gambit for those with the wherewithal to do so, but it isn't very good news for those small local companies who have been faithfully providing quality service to their patients for many years.

Perhaps the only positive thing that we have to say about the process is that it gave CMS the opportunity to finally embrace the concept of requiring accreditation as a prerequisite to participating as a Medicare DME provider. The HME industry has promoted the accreditation concept as a way of weeding illegitimate “suppliers” out of the system. There has been a great deal of attention paid to DME fraud over the years, and accreditation is a great tool for ensuring that only legitimate providers do business with Medicare. It is unfortunate that CMS resisted this idea for as long as it did. There should be no room for fraud in this system, and the HME industry supports the use of the accreditation tool as a means of separating the good providers from the bad.

Is Competitive Bidding Good Business or Bad News?

Acting CMS Administrator Kerry Weems recently referred to the DME competitive bidding process as one that used “market-based competition to increase efficiency in Medicare.” He went on to declare, based on the DME experience, that “competitive bidding can reduce spending, while assuring access and quality.”

There has been absolutely no information released to the public that any meaningful savings have been realized as a result of the DMEPOS competitive bidding exercise. CMS hasn't released information on how many DME providers submitted bids, nor have they indicated whether the initial bids were sufficient to ensure that each product category is adequately covered in each bidding area. There is no guarantee that every provider selected will be willing to commit at the CMS fixed price for three years, particularly if that price is lower than a company's bid price.

It is highly unlikely that CMS is in a position to offer DME patients living in competitive bidding areas any realistic assurances on either access or quality. It would be nice if they would come forward with any information at all. It would be nice to have an accounting how much this initiative has cost taxpayers to date. Since DME represents

such a miniscule portion of the overall Medicare budget, it would be interesting to see whether the funds invested to date are sufficient to justify the projected savings.

But let's focus for a moment on CMS' contention that DME competitive bidding represents a "market-based efficiency." It is, at best, dubious to suggest that this program represents anything close to market economics or that it is an exercise in running government like a business.

It's important to remember that government is not a business and its role in a free market economy, while extensive, is best limited to the things that it is designed to do. This would include providing the legal structure for businesses to operate, maintaining competition (guarding against monopolies and market concentration), the redistribution of income through programs such as Medicare, and providing public goods and services.

Competitive bidding is a tool that can be used to great effect by government so long as it is carefully targeted and promotes competition. Think highway and facility construction projects or even office supplies or local trash collection.

The CMS DME competitive bidding process is none of these things. It is complex, far-reaching and burdensome. It is a government-sponsored scheme to eliminate competition by dismantling a national network of HME providers that has reliably serviced the home health needs of Medicare patients for decades. Medicare beneficiaries, CMS and this Congress will live to regret the day that this network of independent DME providers was dismantled as a result of this ill-considered program.

If Medicare were a private insurance plan, it would be the dominant insurer in this market. If that dominant insurer decided that it only wanted to deal with five or six DME providers in a metropolitan area instead of 100, that would be considered market manipulation. The government would investigate and rightly so. CMS is attempting to manipulate this market for purposes that will not result in savings, that will not ensure better service for people in need, that will result in layoffs, that will result in small business closings and that will result in the loss of tax revenues to state and local governments.

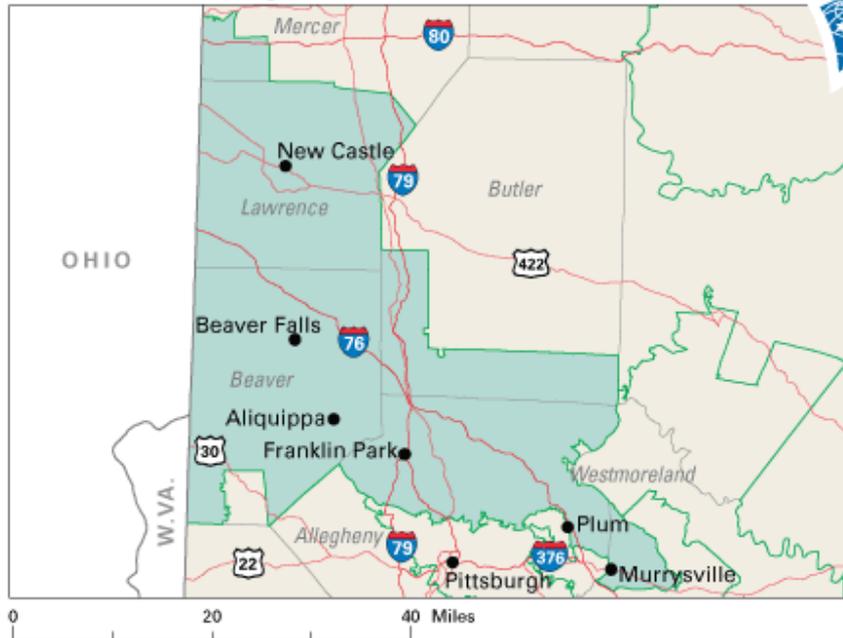
The Medicare population is growing larger and older with each passing year. For the HME industry, that means a growing market. Under free-market economic theory, that should mean that more competitors should be entering this market, helping to drive down or stabilize prices in the face of increasing demand.

It is inconceivable that it would be the U.S. government that would come forward with a scheme to concentrate market share and eliminate competition given such conditions. What CMS is doing is a formula for certain higher prices down the road. Competitive bidding for DMEPOS is not good business. It is bad news. The most responsible thing that this Congress can do on this count is to admit that a previous Congress made an error in approving a poorly considered provision. I urge this Subcommittee to support the repeal of competitive bidding and to set this nation's small

and independently owned HME providers free to meet the needs of America's aging population.

We thank you for this opportunity to testify.

Congressional District 4



4 Congressional District
 Beaver County



Pennsylvania (19 Districts)

Pittsburgh, PA Competitive Bidding Area for all Product Categories Except Mail-Order Diabetic Supplies

