

**House Committee on Small Business
Subcommittee on Rural and Urban
Entrepreneurship**

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Competitive Bidding for Durable Medical Equipment

Testimony of Dr. Jon R. Einfalt, PharmD, RP

Thank you, Chairman Shuler and Ranking Member Fortenberry for allowing me to share my thoughts on CMS's competitive bidding process for durable medical equipment. I appreciate this opportunity to share my impressions on this change in the Medicare program.

My name is Dr. Jon Einfalt and I am a pharmacist/owner along with my wife, Dr. Michelle Ernesti-Einfalt, PharmD, RP, and partners, Dr. James Perry, PharmD, RP and his wife Judy Perry, of Tom's Rexall Drug, a small, independent, rural pharmacy located in West Point, Nebraska. I am a third-generation pharmacist and my wife is a second-generation pharmacist. All of that experience is in rural Nebraska. West Point is a small town in northeastern Nebraska and a part of Congressman Jeff Fortenberry's district.

Tom's Rexall Drug provides the West Point area with complete prescription services; drug information services; unit-dose prescriptions for the assisted living facility in West Point; compounding; durable medical equipment (DME) and supplies; over-the-counter (OTC) medications; consulting services for Franciscan Care Services Hospice; and pharmacy staffing for St. Francis Memorial Hospital in West Point. We have 10 full and part-time employees and our professional staff earns approximately 20% less than the current average salary for pharmacists in the Midwest. The building our store is located in has been an independent pharmacy, under several names and owners, for over 100 years. We have a higher concentration of elderly patients than other parts of Nebraska; therefore, our volume of Medicare/Medicaid business is slightly higher than the average of 40%. Last year we had a net profit of \$20,000 on sales of \$2.375 million. This was slightly worse than the average net profit of 2-3% of sales for an independent pharmacy.

There are approximately 23,000 independent pharmacies located across the country. Many are located in rural areas. This is the case in Nebraska, and many of these pharmacies represent the only healthcare available in their community. Currently

Nebraska has 19 of 93 counties without a pharmacy. Unless some changes start taking place, this number will certainly increase.

In the day-to-day care of my patients, I sell durable medical equipment (DME) and supplies like canes, walkers, diabetic testing supplies, and nebulizer drugs. These products are the tools patients use to treat their chronic diseases and improve their quality of life. For years my patients have depended on me to provide these products and the education necessary to use them properly and effectively. Independent pharmacies have handled sales of DME for decades. Their sales volumes vary tremendously, but their average DME business is about \$280,000. My business is much smaller, so my sales run in the \$50,000 range. The majority of my sales involve diabetic testing supplies and nebulizer drugs. Even before the implementation of competitive bidding, CMS controlled the reimbursement for these items. In fact, the reimbursement for diabetic testing supplies has not changed for several years. In addition, CMS has greatly curtailed the ability of independent pharmacists to provide some of these vital supplies to patients by setting reimbursement rates well below the acquisition costs of the supplies.

Competitive bidding was introduced by CMS as a tool to control costs. I believe the rules and regulations CMS has implemented with this program will eventually have the exact opposite effect, and costs for this program, other government healthcare programs, and out-of-pocket expenses for my patients will actually increase. The increased costs and significant administrative burden associated with competitive bidding and accreditation will eliminate rural independent pharmacies and other small suppliers from the program. In addition, accreditation will cause hundreds, if not thousands, of small, rural independent pharmacies to close. Competition for supplying DME will decrease and the cost of DME will start to increase. Rural jobs will be lost. Patient access to healthcare will be limited. The 20% portion that patients pay out of their pockets for DME (some patients pay 100%) will increase. To save money, patients will

stop using their durable medical equipment and supplies. Hospital and long-term care visits will increase, and the small savings garnered in the first few years of the competitive bidding program will be quickly lost due to increased utilization of these higher cost healthcare facilities. (This does happen. I can think of several instances like this, involving my patients, in the last year.) This is not a new patient behavior or economic concept. We have seen this exact healthcare scenario played out before.

For the purposes of this discussion, let's look at blood glucose testing strips. They represent approximately 60% of my DME sales. Through a complicated and sometimes impossible process of contracts and rebates, I can buy testing strips from the manufacturers for \$22 to \$29 per box of 50 strips. CMS currently reimburses patients or pharmacists \$33 per box of 50 strips. Last year I sold approximately 250 boxes at \$22 cost and 600 boxes at \$29 cost. That makes a gross profit of \$5150 on \$28,000 in sales. Remember that profit number; we'll watch it disappear in a minute. Blood glucose testing is a relatively simple process, and modern equipment is fairly user friendly. However, seldom does a week go by that we are not helping a patient deal with a blood glucose testing issue. These patients are confused about equipment operation and procedures, and some of them have been testing for a number of years. All of these contacts require face-to-face interaction and hands-on equipment. I cannot remember the last time I was able to resolve one of these issues over the phone. Some of these patients receive their supplies through the mail, so obviously the mail order supplier was unable to resolve the issue. In fact, some of these suppliers tell their customers to take their equipment and their problem to their local pharmacy and have us resolve it for them. Pharmacists routinely provide this type of valuable consultation, often at little or no cost to the patient. That will be difficult when we are not around anymore.

Getting back to the numbers --- the costs in time and money to implement competitive bidding and accreditation are prohibitive for small, independent pharmacies. Estimates by CMS, the

associations to which I belong, and the buying and contracting organizations with which I'm involved provide the following projections for participation. Costs associated with preparing and placing a bid are approximately \$2000, and I have not seen any estimates of the time involved. Costs associated with obtaining a \$65,000 surety bond are about \$2000. The cost simply to obtain accreditation from one of the CMS approved accrediting organizations and a Part B supplier number is estimated to be from \$4000 to as much as \$20,000, with a time commitment over the six month period leading up to the actual site survey of 200 plus hours. These are not one-time costs. Most of them repeat at one to three year intervals. Most rural, independent pharmacies are single owner operations. I don't know how they are going to find the time to prepare for and implement accreditation. Remember my gross profit number from above? If I'm going to see that number decrease because of competitive bidding, then you can understand that I will not be seeking accreditation or selling any durable medical equipment.

There is, however, a more ominous and perhaps catastrophic problem looming here. It comes from the pharmacy benefit managers or PBMs. Their smiles must be large and numerous. If CMS requires accreditation to participate in Medicare Part B, then the next contract I have to sign with the PBMs to fill prescriptions for Medicare Part D (and more than likely all the other commercial insurance plans) will require accreditation. 93% of the prescriptions I fill are governed by a PBM contract. Say goodbye to Tom's Rexall Drug. What the PBMs could not do through their own rules and direct competition, the government is going to do for them.

Pharmacies in Nebraska are licensed and inspected by the State of Nebraska on an annual basis. Pharmacists are also licensed by the state. Both are governed by a comprehensive set of rules and regulations overseen by the Nebraska Department of Health and the Nebraska Board of Pharmacy. I do not need federal accreditation to practice pharmacy or sell durable medical

equipment and supplies. It adds nothing to the quality of the pharmaceutical care I provide my patients. I could negotiate that section out of future contracts, but as an independent pharmacy, the chances of that occurring are not real. Without Congress acting to give business negotiation capabilities to small pharmacies by passing legislation like HR 971, my ability to negotiate fair contracts with giant PBMs is non-existent.

So where does this leave the patient, my patient, your constituent? As you consider the testimony given today, think about the patient first, just like pharmacists and healthcare workers do everyday. A misguided plan to produce some short-term savings in DME costs has suddenly changed into a plan that decimated the access to quality healthcare for rural Americans and increased the overall cost of healthcare for the government. A mailbox is not a pharmacy. Pharmaceutical care cannot be delivered to a mailbox or provided over the phone. It takes contact with patients to be done correctly. If a patient needs an antibiotic, pain medication, insulin, asthma medication, or even a blood glucose testing strip, whether it's a new need or he/she forgot to re-order the product, they can't wait three to ten days to get it in the mail. That means a drive, sometimes a long drive, or doing without. That certainly does not provide an improved quality of life, and unfortunately, in some cases it will mean something much worse.

The June 2008 issue of Consumer Reports once again shows independent pharmacists at the top of the ratings. Rural American pharmacists are independent pharmacists. The Consumer Reports article also has some warnings. Independent pharmacies are under the gun and may be a dying breed. It began a decade ago with the rise of the PBMs and their low reimbursements and continues now with the government and its increased volume and slow reimbursements for Medicare Part D. Independent pharmacies need help from Congress and we need it now. We need HR 1474 so that we are paid promptly and HR 971 so that we have true negotiating power, and we need Congress to tell CMS to fix this

mess involving competitive bidding and accreditation. The drop-dead date (not my term, but interesting considering the situation) for accreditation is September 30, 2009. Many PBMs and other private insurers may soon adopt the Medicare accreditation requirement. Early statistics from the first round of competitive bidding show the scenario I have outlined is already underway. Less than 40% of the suppliers that CMS projected would submit bids actually did. The actual participation of independent pharmacies, as a percent of CMS projections, appears to be much worse.

Ladies and gentlemen, we're going to need your help on this one. Rural, independent pharmacies cannot change these rules or absorb the costs. The high costs of participation and the problem of accreditation must be fixed before this program is expanded. There is little or no cost to the government to fix these problems. The government already controls the cost of durable medical equipment and supplies.

Thank you for inviting me to participate in your discussions. I hope the information I have provided will be useful as you move forward.