



**MOUNTAINEER OXYGEN SERVICES, INC.**

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

**“Medicare’s Durable Medical Equipment,  
Prosthetics, Orthotics and Supplies (DMEPOS)  
Competitive Bidding Program”**

**May 21, 2008**

**Testimony of Mr. Heath Sutton  
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**On behalf of the**

**North Carolina Association  
for Medical Equipment Services**

Testimony  
of  
Mountaineer Oxygen Services, Inc.  
before the  
Subcommittee on Rural and Urban Entrepreneurship  
of the  
Committee on Small Business  
of the  
U.S. House of Representatives

Medicare's Durable Medical Equipment, Prosthetics, Orthotics and Supplies  
(DMEPOS) Competitive Bidding Program

May 21, 2008

Good morning Mr. Chairman and distinguished members of the Subcommittee. I am Heath Sutton. I am a respiratory therapist and am the President and founder of Mountaineer Oxygen Services. My home medical equipment practice is based in Waynesville, North Carolina with a branch office in Sylva, North Carolina. My wife and I started our home medical equipment company to focus on the care of homebound oxygen patients and patients with sleep disorders.

Our company was founded to meet the needs of patients in a small town environment. We are slated to be in Round Two of the Medicare bidding program based on the location of our practice. Having seen the devastating results that this program has caused in Round One, we are desperately concerned about its impact on both small providers like ourselves and the patients we take pride in serving.

We began our company with the motto "Treating Patients Like Family". This motto is printed on our forms and is painted on our company delivery vehicle. Since founding our practice over five years ago, we have consistently devoted ourselves to meeting this standard. Throughout our history we have been proud to serve the needs of Medicare beneficiaries and these patients have always represented about 75 percent of our business.

My wife and I are proud examples of the American dream since we founded and built our own business. We recognize that health care costs are escalating and fully appreciate the efforts of our government to gain control over the expanding costs of government programs, including Medicare.

However, I am not convinced that the recent changes implemented by Medicare, given the misleading name of "competitive bidding," will accomplish either lower

overall costs nor strengthen health care for our elderly and disabled members of the population. Instead of increasing competition, this new program will result in market concentration with only a few home medical equipment providers.

The first phase of program implementation has illuminated serious difficulties with the program. If the goal of the program was to provide better care at lower prices, I strongly believe that those changes will do neither.

The most serious problem we see is the lack of access of patients to quality health care. Results from Round One of this program have clearly shown that nearly 2 out of every 3 providers, although fully accredited and currently serving the market, were disqualified from participation. Based on CMS' own calculation of the number of home medical equipment providers in the 10 areas subject to bidding in Round One, CMS has chosen to contract with only about seven percent of providers in these areas. This enormous reduction in the number of providers able to serve Medicare beneficiaries for services and items subject to bidding will most certainly result in a large scale reduction of access to quality of care for the majority of Medicare beneficiaries. How will it be possible for the more than 200,000 home oxygen patients to receive proper and acceptable care from less than 10 percent of the current providers?

Furthermore, some of the "winning bidders in Round One gained contracts for geographical areas they have never covered. How can they serve these areas unknown to them and more importantly how can they do so by July 1, 2008, which is when program implementation begins?

There are only two possible options:

1. Quickly open locations inside the new areas and try to staff and supply those new locations within weeks.
2. Subcontract with local providers already inside the new areas.

If the second option is chosen, the bidding program, as currently devised, gives no assurance that the subcontractor will be accredited, which on its face violates the spirit of the recent Medicare change to only approve reimbursements to fully accredited providers that can provide quality care to Medicare beneficiaries.

This flawed program, which will impact an additional 70 MSAs later this year, will again replace currently accredited providers with unaccredited subcontractors serving the beneficiaries. Winning contract suppliers may have never served those patients before and access to quality care for a large number of current patients will be reduced significantly under the bidding program.

Let me share with you an example of the type of patient that will be impacted by this program, We currently serve an elderly patient with severe COPD and chronic hypercapnea, which is an excess of carbon dioxide in the blood. She is

the first oxygen patient that Mountaineer Oxygen Services set up on home oxygen in October 2003. She lives alone and has no family. At least once a week she calls our on-call service between 9-10pm on her way to bed asking for help to attach her water-bottle onto her oxygen machine. She panics when she cannot get her oxygen bottle re-connected and has us on her speed dial. Once a week for the past four years our on-call person knows he must drive out and assist her. Several times she has panicked and been unable to dial our number and calls 911. This patient will suffer emotional stress and potentially serious health consequences if we lose the bid in Round Two, not to mention if the Round Two bidder is over 100 miles away. She relies on us to care for her needs.

We hope that all involved at the Federal level will understand the gravity of the changes that are about to occur in the home medical equipment and service benefit. Small providers who have spent their lives taking the risk to start their own practices and have built their businesses on serving a population base that comprises about 50 percent of Medicare patients may quickly fail due to being excluded from the marketplace. These providers are serious, diligent, hard-working Americans who have been devoted to their Medicare beneficiaries' needs for many years. They are providers who have made substantial investments in both their firms and in accreditation to be qualified to serve Medicare beneficiaries.

The majority of American jobs are created by small businesses, not large corporations. We need these jobs for the U.S. economy in these uncertain times of massive outsourcing of American employment.

In large metropolitan areas, job losses may not be seen as catastrophic, but in a moderately-sized or small town market, as further phases of the program are implemented, small business failures will be significant. Will the larger providers be willing to commute to the outskirts of bidding areas to properly service the needs of those patients at significantly reduced payment rates? If they try to subcontract the work, will profit margins support two companies at the newly established payment rate?

Having seen and heard how Round One has been implemented, I believe that successful bidders submitted unrealistically low prices for products which they have never before provided to the market. These firms have no experience in the provision of these products and services yet their bid prices were used to calculate the new payment rate.

Round Two providers are going to look to the prices established in Round One and make the decision that they must bid below those Round One payment rates to receive a winning contract from CMS. It is a desperate vicious cycle with no winners. Providers will be forced to cut services or the quality of products. There will be wide-scale business failures because suppliers will lose a meaningful

portion of their revenue base. And those who have the most to lose will be patients who have come to rely on their local small provider. They may be required to go to the hospital, call 911 or visit their physician more frequently. None of these costs has ever been considered as part of bidding. This program is not a market-based system that rewards quality and innovation. Instead, it is selective government contracting that may well begin the destruction of our nation's homecare safety net and lead to higher costs.

What also troubles me is my government's seeming unwillingness to share with the public even the most basic information about this program. How were the new payment rates established? What criteria were used to evaluate the financial wherewithal of homecare providers and their expertise in the provision of bidded items and services? These questions are in addition to the fundamental problems of the bidding program which resulted in the disqualification of more than 60 percent of suppliers who tried to participate.

I also find it dangerous to consider that bid pricing could be applied to non-bid areas beginning in 2009. Payment rates established through bidding in Miami or Dallas are not reflective of the cost of business in non-urban areas.

On the oxygen side of the business, the problem has become more complex. Even before bidding was implemented, providers knew that on January 1, 2009, the transfer of ownership of oxygen equipment and the 36-month payment cap will surely bring negative impacts to the patients and providers in the latter months of their 36-month period. Any patient who must change providers late in their period will find it difficult, if not impossible, to find a provider willing to arrange the same level of quality equipment or even modest care for an extremely low return.

Finally, we remain skeptical that the relatively minor savings on the DME products involved (as a percent of Medicare overall spending) has been analyzed thoroughly, with acknowledgement of the added costs to Medicare of patients who may find it necessary to show up at the hospital emergency room to receive care because their local provider no longer can serve them and the subcontractor may be many miles away. Current estimates show that DME outlays by Medicare average around \$8 per day. Average emergency room visit costs just over \$4600 per day.

I ask the House and Senate to delay this flawed program from proceeding and to work with those of us closest to the markets to arrange a proper program, fair and effectively priced to serve those in greatest need. I would like to remind you that history judges nations not by how they treat their leaders but rather how they care for the most vulnerable in our society.

I thank you for giving me the opportunity to testify before you today.