

Small Business Committee Testimony: Gerald Sloan

Thank you Chairman and Committee members for the opportunity to come and share my story and our industry's small business concerns. My name is Gerald Sloan and I am the founder and owner of Progressive Medical Equipment located in Kansas City. My company is defined as a small business by SBA standards and barely so as defined by CMS. We will be celebrating our 10th year of doing business this April. We currently employ 18 individuals that service the 5 county area of Kansas City, the 4 county area of St. Louis, and most counties throughout Central Missouri. Although we specialize in servicing mobility needs, we are a full line DME company that provides among many things, standard items such as Oxygen services, Hospital Beds, and Bath Accessories. This allows us to be a single point of contact for most our referral sources.

I come before you today to tell the story of Competitive Bidding from a small provider point of view. Like many small DME's across the United States, we began the Competitive Bidding process with much trepidation and uncertainty. Although CMS had promised to install safeguards into the system such as requiring a target of 30% small provider participation to protect small providers, we realized that this actually meant thousands of us would be excluded. Additionally, because the program had no transparency in determining winning bids, we felt and many actually realized that they could be excluded without any refutable cause. Any error in processing by the administrators of the program could devastate or eliminate the chances of any provider from participating. CMS recognized that they had made errors and overturned participation for some providers, but many such as Todd Tunison of Summit Medical, a small DME in Lee's Summit, MO were turned away with vague references to inability to meet financial standards but with no specific explanation.

When we began submitting our bids online, our worst fears were soon realized. The system was not ready for submittal of bids. My company was the first to notice and notify the contractor that the system was asking us to bid in zip codes that were not part of the Kansas City Metropolitan Statistical Area. We were also asked to bid on a code whereas no product was available for the code. If we left the area blank, our bid would be thrown out as incomplete. The best guidance we received from CMS was that by filling out "not applicable" our bid *should* be fine. In other words, a guess was dictating our future.

We were also required to bid below the current allowed amount for each code. There were numerous items that we bid that were already priced below our acquisition cost. This requirement seemed grossly unfair. If the project were to be deemed truly fair to the provider, wouldn't it allow us to bid up for products that we have historically lost money on?

In short, the bidding process was poorly run and left much room for doubt. It was difficult enough alone not knowing whether our bids would be good enough to continue with the Medicare program but couple with the knowledge that errors were being made

continuously throughout the bidding, we were left wondering how we would continue with the program despite our preparedness and willingness to do so.

We eventually were selected to participate in 4 of the 5 categories that we bid: Complex Rehab, Consumer Power Wheelchairs, Walkers and Related Accessories, and Hospital Beds. Although we won our bids, I still feel strongly that CMS did not do enough to protect small providers and ultimately favored large national companies. Evidence of this can be found directly from the booklet received by Medicare Beneficiaries prior to July 1, 2008 announcing the program and winning providers.

My company, Progressive Medical Equipment, was one of two local providers to win in the Complex Rehab category. The other two winners, Scooter Store and ATG Designing Mobility had never participated in this category in our MSA. To the best of my knowledge, neither is currently doing so. Also, one will find that the Scooter Store, a national provider of Consumer Power Wheelchairs is listed 3 times as a provider to call in our MSA. Everyone else was listed only once.

In the Consumer Power Wheelchair Category, Apria, another national provider was listed 14 times for Power Wheelchairs. Scooter Store, again, was listed 3 times. This means that of the 31 listings for Providers in this category, 17 were these two companies.

The Walkers and Related Accessories shared the same common theme. Of 33 listings in the booklet, Lincare, a large national company is referenced 14 times. Scooter Store has 3 listings.

As for the Hospital Beds and Related Supplies category which features 49 listings, Apria is listed 14 times, Lincare 14 times, and Scooter Store 3 times. In other words, 31 of 49 listings, or 63%, of the listings were divided among these 3 large national providers. No small provider was given more than 1 reference per category.

I would also like to point out that Scooter Store won in every category in our MSA. CMS has been adamant about the quality of service not being compromised in this acquisition program. But one must ask, how did a company that has never provided Oxygen Services, Hospital Beds, Complex Rehab, etc., let alone in our MSA, be selected to do so?

Additionally, as recently as 2007 Scooter Store settled with the Department of Justice for the sum of \$17 million dollars to ward off the conviction of Medicare fraud. Apria did the same for approximately the same amount in 2005. Lincare settled in 2006 for \$10 million to stave off convictions of violating the anti-kickback laws. All the companies denied any wrong doing by settling. But the implication is quite clear. You don't pay this kind of money if you didn't do anything wrong.

As directed, CMS did make attempts to inform Medicare Beneficiaries of the DME benefit changes. The attached letter and booklet show the extent of their efforts. Both the letter and booklet are confusing and misleading. None of the material addressed the

capped rental issues that surrounded oxygen. We fielded more than 25 phone calls in the first few days of competitive bidding from our customers confused about the changes in the program. At one point, we were so swamped with calls that we couldn't handle our regular business.

Perhaps the greatest and longest term ramification of the Competitive Acquisition program for my company rests in our Oxygen Service. As you may be aware, Congress passed a 36 month cap payment for Oxygen Concentrator reimbursement. The first of the capped rentals were scheduled to occur in January, 2009. When we were submitting bids for oxygen, we were still waiting on a final rule of what would happen after the 36 month cap. Questions such as, "who would own the equipment and what kind of service calls would be reimbursed", were left unanswered by CMS. Without this knowledge, I felt that as a small provider with very limited numbers of Oxygen referrals a month it would be unwise for me to gamble that the terms of the cap would be financially feasible for us. Therefore our bid was higher than the accepted bid amount and we lost the bid.

In anticipation of losing the Oxygen category, we began to reduce our marketing in this area right after we submitted our bids. By July 1, 2008 we were down to 1 to 2 referrals a month—down from 6 – 10 referrals. Just a few years ago we averaged 75 – 100 Oxygen clients. Our number currently stands at 27, 24 of whom are capped out with no reimbursement for our service. So in short, our Oxygen service is dead because of Competitive Bidding. Not only do we lose, but so does our community who depends on us for very personalized and committed service. Customers who were disgruntled with the service they received from large national companies switched to us regularly. Stealing customers from the national companies was easy for us because none could care for their customers like we could. Competitive Bidding provided the perfect venue for large companies to eliminate real competition from small providers.

Another major concern with the Competitive Acquisition program was the inability to adjust bids because of economic factors. We made bids in the summer of 2007, long before the price of gas began its well know spike. By the time the program started in July of 2008, the price of gas had doubled. The effect of the rise was not only felt in our fleet, but in the price of our products as well. Every supplier we used began adding fuel surcharges to our shipments. Some started requiring minimum orders before they would ship. This had a devastating effect on our ability to maintain the margins necessary to remain profitable. Thankfully, the program only lasted two weeks but one has to wonder how long could we have lasted in a three year contract under such conditions?

Finally, I would like to comment on CMS's willingness to listen to providers regarding the Competitive Acquisition program. Although they paid lip service to creating a committee to guide them, in reality the PAOC or Program Advisory Oversight Committee was never given much consideration. The original committee was disbanded and a new one was formed in the last three months. Of the 17 members of the committee, only 4 are providers of DME services. Even with letters of recommendation from the Mid-West Association for Medical Equipment Suppliers and Senator Roberts plus my experience with round one, I was not ask to help make the program successful. I'm

confident that there were many others who volunteered with equal or better qualifications that were also denied. It appears that CMS simply does not care to implement a fair and reasonable program.

In conclusion, I would like to say that the DME industry has been attacked by CMS and Congress for too long for problems we did not create. Fraud has been the ballyhooed cry to justify this persecution. I am before you today to testify that the guilty party is not our industry but is CMS. CMS is charged with maintaining program integrity, yet they continue to allow unscrupulous and nefarious criminals access to Medicare Provider numbers. Even when given a mandate to create a new program designed to cut down on fraud, they allow contracts to go to companies that have been investigated for fraud and who have paid settlements. They have proven time and again, that they are poorly managed and cannot deliver program integrity. Yet we are to believe that they have small business interests in mind, that despite no transparency in the process we are to trust them with decisions that affect thousands of companies and tens of thousands of employees and their families. I come before you to ask the Small Business Committee to find a way to strike down this program before it hurts anyone else.