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Congress Must Suspend the Pending Restart and Repeal Competitive Bidding for DME

These comments are submitted for the record in conjunction with the hearing held by the House Small Business Sub-Committee on Rural and Urban Entrepreneurship on February 11, 2009

The **National Association of Independent Medical Equipment Suppliers (NAIMES)** strongly urges Congress to immediately suspend the pending restart of Round One of the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and ultimately repeal the provisions of the Medicare Modernization Act of 2003 (MMA03) establishing this program.

This flawed program is bad public policy and will neither save money for Medicare, nor reduce fraud and abuse. A program of care based on the lowest bid will create a two-tiered system for DMEPOS and restrict patient access to care. The statute also unconstitutionally eliminates due process for participating suppliers by waiving federal acquisition regulations and removes all administrative and judicial review.

Despite the outcry from Congress and the public, the Centers for Medicare and Medicaid Services (CMS) began implementing the program in the first 10 of 80 areas of the country in July 2008. Although ultimately delayed as a tremendous cost to providers, CMS is now set to restart the program without making substantial changes to the rules. Reports clearly showed that there were serious problems with the program during the 15 days it was in effect.

Although Congress made changes with the passage of the Medicare Improvements and Patient Protection Act of 2008 (MIPPA) and was designed to address some of the concerns raised by the supplier community, fundamentally the program remains intact and still has most of the same concerns. With the procedural flaws, operational problems and other irregularities that have repeatedly been brought to the attention of CMS, it is clear that there are serious problems in the manner in which competitive bidding is being implemented and the fairness of the overall process. There is neither transparency nor adequate procedural controls as CMS now restarts the program without significant changes. Congress must now exercise proper oversight and repeal competitive bidding before grievous harm is caused to millions of beneficiaries and tens of thousands of small businesses. The intent of Congress will not be met by this program; and it threatens the financial viability of a large number of qualified and accredited DME suppliers as well as the future of the entire industry.

One of the most critical issues with competitive bidding is the lack of understanding of how the DME industry functions. The DME supplier community is made up of providers who serve a local service area, sometimes as small as a few miles in an area. In most cases, these service areas are literally a community, particularly in large metropolitan areas. The bidding process of requiring a bid winner to serve the entire competitive bidding area (CBA) is in itself exclusionary. An accredited provider serving the western most part of the Riverside, California CBA would find it physically impossible to serve the easternmost area. Expecting that same supplier to subcontract in order to stay in business would require business expertise far beyond most small businesses.

Another serious problem with the bidding program occurred with the start of round one in July of 2008. Referral sources were unable to find suppliers who could serve their patients. Sometimes a physician's staff would have to call 4 or 5 suppliers to obtain the same services they were ordering previously from a local supplier they knew and trusted. Often when a supplier was located, there was a delay of several days to obtain equipment due to either the distance the contracted supplier had to travel, or the equipment would be shipped by UPS to the patient. This caused additional costs in many cases due to a patient not being able to be discharged without available equipment.

Suppliers who were not selected for a contract were contacted by a bid winner who did not have a presence in the local area and offered a contract. In numerous cases, the non-contract supplier was told that they would be paid 80% of the contract fee to handle all aspects of the service, with the exception of billing. In most of those cases, the bid winner told the subcontractor they would not be paid until after the bid winner was paid. There were cases where an oxygen provider with one location in one CBA won a contract for 8 of the 10 CBAs with no ability to serve the areas thousands of miles away.

In all of the CBAs, there were bid winners in equipment categories with no experience or qualified staff to perform the service. Often these bid winners bid low expecting to win with the sole purpose of making "a fortune" by finding subcontractors to do the work. They were then left unable to serve the patient's needs because the fees were too low for any subcontractor to accept the patient. In one case a small pharmacy won a bid for power wheelchairs, but had never provided power mobility before.

Other providers bid to win with the intent to seek a buyer for their company if they were awarded a contract, despite CMS rules that placed restrictions on such sales.

The following are the problems and concerns with the original start of Round One that NAIMES has identified.

1. Hundreds of suppliers were improperly disqualified based on errors and unsubstantiated reasons, indicating mistakes and flaws in how CMS managed the selection process.
2. CMS changed the program rules without notifying bidders. There is no indication that the revised implementation rules are any more transparent.
3. Based on CMS figures, more than 1000 suppliers were excluded from the original start in Round One areas. There were approximately 300 bid winning companies to serve all beneficiaries in the bid categories in the first 10 competitive bid areas (CBA). There is no indication in the newly released final rule that changes this outcome.
4. Suppliers who had no presence in a geographical region were awarded contracts. Suppliers were offered contracts to serve all regions without having any viable plan to do so and without any subcontracts with other suppliers to serve bid areas for them. CMS used no mechanism to verify a supplier's ability to meet the bid criteria. Despite the mandate in HR 6331, the new final rule does not clearly rule out this happening again.
5. Suppliers were offered contracts to provide product categories that they have never provided before. CMS did not verify that a supplier was experienced in a product category even though there was claims history available from other Medicare contractors.
6. The bid process and criteria used by CMS made it easy for suppliers to submit a bid without proving their ability to perform under the contract. Most of the information submitted was subjective without any appropriate means for CMS to verify its accuracy.

7. The online bidding software program was fraught with problems and errors as well as being so un-user friendly that undetected errors could be made. Despite claims that this has been resolved, there have been no details provided to prove it.
8. Bid prices were extremely low due to: 1) inexperienced suppliers underbidding, and 2) desperate suppliers wanting to win the contract without regard to servicing the beneficiaries sufficiently after winning the bid. Many suppliers bid purely to insure they would be included rather than understanding that such unsustainable low bids would make a flawed program worse.
9. Due to the elimination of due process in the statute, and the subsequent shroud of secrecy, CMS refused to share meaningful data to allow a third party to assess the likely impact of the program on suppliers and beneficiaries. This is in stark contrast to customary standards of government transparency. The new final rule does little to change this problem and due process can only be restored by Congressional action.
10. The flawed bidding process sets a pivotal bid based on capacity that was not validated by CMS. This resulted in only the lowest bidder's prices being included in the final median fee calculation. This set the new fee schedule lower than suppliers can operate and still remain financially sound. All of the studies related to this program noted that this process of setting the bid amount was seriously flawed.
11. The contract offered by CMS allowed no recourse for a supplier that accepts the bid offer and then finds they are unable to meet the terms of the contract. The only way out of the contract is for CMS to terminate it for breach of contract. This indicates the only escape for a supplier is to go out of business.
12. Contract language indicated that breach of contract can result in the loss of the bidder's supplier number. Failure to meet the bid criteria would eliminate a supplier from the Medicare program completely, even though they can still supply non-bid products in the area. This is unjustly penalizing a supplier who accepts the contract without realizing the consequences.
13. Winning suppliers have no guarantee of any new business since larger companies could capture market share by using their substantial resources to promote their businesses.
14. Physicians contacted by NAIMES have grave concerns about their patients under this program. With their usual list of preferred suppliers reduced by as much as 90%, many are concerned for the well-being of their patients after implementation. In the original start of Round One in July 2008, CMS failed to adequately notify hospitals, physicians, and other healthcare professionals about the changes.
15. CMS failed to provide adequate notice or information to those being affected. By the time bid winners were formally announced, there was less than 60 days to complete this education.

NAIMES is very concerned about competitive bidding and will work with members of Congress to help meet the stated goals for this program following repeal. NAIMES can offer alternatives that will both reduce fraud and abuse, and reduce program costs by applying realistic solutions.

NAIMES cannot emphasize strongly enough the importance of STOPPING this program and urges Congress to immediately suspend implementation while working to repeal these provisions of this flawed program.