

**AAHomecare,
American
Association for
Homecare**

**AdvaMed,
the Advanced
Medical
Technology
Association**

**Coalition of
Respiratory
Care
Manufacturers**

**Coalition of
Seating and
Positioning
Manufacturers**

**Coalition of
Wound Care
Manufacturers**

**Diabetic Product
Suppliers
Coalition**

**Home Medical
Equipment
Association of
America**

**Medical Device
Manufacturers
Association**

**National
Alliance for
Infusion
Therapy**

**National
Association for
Home Care**

**National
Association for
the Support of
Long Term Care**

**Power Mobility
Coalition**

**United Ostomy
Association**

May 24, 2002

The Honorable William Thomas
United States House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Thomas:

The undersigned organizations, which represent a significant portion of the home medical equipment and supply industry, strongly oppose national competitive bidding for home medical equipment and supplies. We believe that it is premature to expand competitive bidding from two demonstration projects to a nationwide basis when the limited demonstrations have not been completed. The impact that competitive bidding can have on patient access to services, quality and choice, and the overall costs of implementing a national competitive bidding system have not been assessed.

The Balanced Budget Act of 1997 authorized CMS to implement five demonstration projects to determine the effect of competitive bidding on the home medical equipment markets, beneficiary access, and diversity of product selection and quality. The stated purpose for having five demonstrations was to assess how competitive bidding would work in diverse areas of the country, such as urban and rural settings, large and small populations, and areas with higher and lower costs of living. To date, CMS has only implemented two limited demonstrations, one in Polk County, Florida and another in San Antonio, Texas. The Polk County demonstration has had two rounds of bidding for oxygen services, hospital beds, wound care supplies and incontinence supplies. Only one round of bidding has been conducted in San Antonio for oxygen services, hospital beds, nebulizer drugs, wheelchairs and orthotics. Both demonstrations are ongoing and will be concluded in September and December of 2002 respectively. Based on the limited data received from the two demonstrations, CMS has estimated that the Medicare program has saved approximately 17% in the demonstration areas. Importantly, to reach this level of savings, CMS had to ignore all administrative costs incurred in these demonstrations. In addition, the savings estimate does not take into account the added program costs associated with administering a more comprehensive bidding process and formal appeal mechanism that should be included in any national bidding program.

While the savings from the demonstration sound appealing, the demonstration projects are incomplete and the results are too inconclusive to justify expanding the project on a national basis. We urge Congress to evaluate and resolve the following issues before implementing DMEPOS competitive bidding nationwide:

- **Competitive bidding results in a lower standard of care for Medicare beneficiaries because it restricts access to services.** Suppliers provide many essential services with the delivery of medical equipment like respiratory therapists and 24-hour on-call assistance. Medicare does not mandate these services, but competition preserves access to them in areas outside of the demonstration projects. In demonstration areas, however, Medicare beneficiaries must call for emergency care or be admitted to a hospital if problems arise during non-business hours. CMS has not measured the costs to the Medicare program associated with shifting these services to other sectors of the healthcare system.
- **Competitive bidding limits beneficiary choice.** Medicare beneficiaries in the demonstration markets can only obtain the demonstration items through the limited number of suppliers designated by Medicare. Because of these limitations, the selection of products patients can choose from is limited by price. Personal preference is extremely important for patients, even for products that appear to be interchangeable commodities, such as incontinence supplies. This has a detrimental effect on comfort, convenience and continuity of care because it limits a patient's choice of products and forces patients with needs for multiple products to obtain them from many different suppliers.
- **Competitive bidding is anti-competitive and harmful to small businesses.** In spite of its name, the competitive bidding process would likely cause unwarranted harm to many small businesses that are valuable assets to their communities. Because the competitive bidding process awards contracts only to those suppliers that are able to offer a qualifying price, many businesses will be excluded from this marketplace. The elimination of small businesses and the decrease in competition would result in a reduction in services offered to Medicare beneficiaries. The elimination of businesses will also mean there will be fewer bidders when it is time to update or renew the bidding process. Bid prices are likely to rise and patient choice is likely to diminish as more suppliers are eliminated.
- **A workable bidding process and appeals mechanism must be established, approved, and tested before Congress could approve a competitive bidding process.** The processes used in the demonstration projects have significant structural and procedural flaws. These flaws will be perpetuated if a national system does not include: (i) a mechanism for "losing bidders" to appeal the CMS decision to award contracts, (ii) a mechanism for protecting the proprietary information of the bidders, once submitted to CMS, (iii) defined parameters regarding the level of services that would need to be provided by "winning bidders," and (iv) a mechanism for ensuring continued quality of the services by "winning bidders."
- **The costs of implementing a national competitive bidding process may outweigh any cost savings to the Medicare program.** It is unclear that the savings from national competitive bidding will offset the administrative costs of

running the program. The demonstration has been too limited in scope and size to assure that the program will sustain the 17% savings when extended nationally. Although the Administration's budget estimates that national competitive bidding for DMEPOS would produce a savings of \$5 billion over ten years, those savings estimates do not account for expanding the small bureaucracy in the demonstration to large metropolitan areas. Moreover, the projected savings are extrapolated from a very limited sample of DMEPOS products in a very small marketplace rendering them unreliable. It is likely that designing and administering a system that assures multiple winners for scores of products in every location will be an immense undertaking.

CMS' own analysis of the first round of the demonstration – the only round that has been completed – states that “it is premature to declare that competitive bidding is either an appropriate or an inappropriate reimbursement mechanism” for durable medical equipment. We agree. At a minimum, competitive bidding should not be extended nationwide until (a) CMS completes the two ongoing demonstration projects, (b) the results of these projects have been fully analyzed, including administrative, financial and outcomes data, (c) additional demonstrations are conducted to provide data about how competitive bidding would work in more diverse areas of the country, (d) a valid assessment has been undertaken by an independent agency or the Congressional Budget Office of the likely savings (or loss) to the Medicare program. We appreciate your consideration of these important issues, and ask that you oppose the inclusion of a national competitive bidding program in any Medicare legislation considered this year.

Sincerely,

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