

**TESTIMONY OF
THE AMERICAN ASSOCIATION FOR HOMECARE**

ON

**MEDICARE PAYMENTS FOR DURABLE MEDICAL EQUIPMENT,
ORTHOTICS, PROSTHETICS AND SUPPLIES**

**APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION**

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The American Association for Homecare (AAHomecare) submits the following testimony to the Senate Subcommittee on Labor, Health and Human Services, Education and Related Agencies in response to the updated comparison of Medicare payment rates to other payers for certain items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). AAHomecare represents all segments of the homecare industry, including providers and suppliers of home health services, durable medical equipment (DME) services and supplies, infusion and respiratory care services and rehabilitative and assistive technologies. Many of the individuals our members serve are Medicare beneficiaries.

In its most recent examination of Medicare payments, the Inspector General of the Department of Health and Human Services (HHS) compares the Medicare payment rate for sixteen items of DMEPOS with the rates paid by the Department of Veterans Affairs (VA), state Medicaid programs, retail establishments and the Federal Employee Health Plans (FEHPs). The OIG review is a rehash of its previous studies, essentially reaching the same conclusions without addressing any of the systemic differences between the programs it compares. The OIG contends that its conclusions support its previous findings that CMS could achieve significant savings by adopting any of the alternative payment systems of the four programs listed above. However, in this recent comparison -- as in the OIG's previous studies -- it fails to account for the structural differences in the programs and the additional administrative costs of providing DMEPOS to Medicare beneficiaries, which are described in greater detail below.

The OIG's Comparison of Medicare to Other Programs is Fundamentally Flawed.

Comparing the VA to Medicare is like comparing apples to oranges. The fundamental differences between the methods used by the VA, Medicaid, the FEHP or retail suppliers and Medicare suppliers to purchase, deliver and get paid for items of DME and supplies render it inappropriate to compare payment rates between them. The industry has higher administrative costs when servicing Medicare beneficiaries than it does other patient groups. Medicare providers spend a significant amount of time and money filing claims for Medicare reimbursement and obtaining documentation to support the claim. The differences between the Medicare program and the VA have, for example, been recognized by the GAO¹ and the OIG, and the OIG has held that the higher costs of servicing Medicare beneficiaries can justify higher charges to Medicare by suppliers.² Suppliers must document the medical necessity of each claim, obtain a prescription from physicians, often must request portions of the beneficiary's medical record to document medical necessity and must document proof of delivery. Providers also incur the expense of billing and collecting Medicare co-pays and deductibles and bear the risk of bad debt.

Moreover, VA payment amounts do not reflect the costs for delivery of the items because they are absorbed under other parts of the VA budget. The VA purchases items directly from manufacturers and distributes them to beneficiaries through the VA facility network. Unlike

¹ Comparison of Medicare and VA Payment Rates for Home Oxygen, Letter dated May 15, 1997 from William Scanlon, Director, Health Financing and Systems Issues, GAO to William Roth, Chairman of Finance, United States Senate.

² See OIG Advisory Opinion, No. 98-8.

most homecare suppliers, the VA can purchase directly from manufacturers in large quantities. There are many small homecare suppliers that may serve only two or three hundred beneficiaries each year. The VA, in contrast, can commit a large volume purchase to a manufacturer.

In contrast, Medicare suppliers provide beneficiaries with services and delivery of the items that are not directly reimbursed by the Medicare program. Transaction costs for servicing Medicare beneficiaries are higher than they are for VA patients because of the significant cost of complying with Medicare program rules. Medicare suppliers must meet twenty-one supplier standards which include maintaining a physical facility, delivering items to the beneficiary, providing education to the beneficiary and maintaining a complaint resolution procedure.³

The OIG attempts to address the disparities between the VA and the Medicare program by incorporating a 67% mark-up from VA payment rates into its analysis. However, this mark-up amount derived by CMS bears no relationship to a provider's costs of furnishing DMEPOS items. CMS calculated the percentage based on the suggested retail price for items in the manufacturers' requests for HCPCS codes spanning over ten years. Not only did CMS use stale data, it did not undertake any analysis of the costs to providers of participating in the Medicare program. The 67% figure is arbitrary and should not be given any weight as a benchmark for Medicare payment amounts.

The Medicare Program Can Not be Directly Compared to Other Public or Private Insurance Programs or Retail Establishments

The OIG also compares Medicare payment rates to state Medicaid programs, the Federal Employee Health Plans and retail operations. These comparisons are equally flawed because they compare Medicare to drastically different health care delivery models.

- Medicaid programs vary widely by state and it is therefore imprecise to compare Medicare reimbursement rates to an amalgamation of Medicaid rates. For instance, some Medicaid programs have large participation by managed care companies. In addition, many Medicaid programs offer a simpler, more predictable administrative framework which include mechanisms like prior approval which streamlines the reimbursement process and guarantees that the supplier will be paid for the items it provides.
- Many Medicaid programs have regional concerns that affect the payment for DMEPOS in that state. For instance, the Wisconsin Department of Health and Family Services recently responded to an investigation by the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) that found that the Wisconsin Medicaid program could save money by reducing its reimbursement rates for oxygen to the Medicare rate. In refusing to accept the OIG's recommendations, the Department stated "while we agree with your conclusion that Wisconsin Medicaid pays more than the Medicare rate, we disagree with the recommendation that we reduce our payment level to match Medicare. It remains our belief *that such a reduction would result in the refusal of providers to serve Medicaid clients. It should be noted that many of the fiscal*

³ See 65 Fed. Reg. 60366 (October 11, 2000).

disparities that resulted from the 1997 Balanced Budget Act have been identified as causing a loss of providers, and that many of those limitations have since been rescinded. Therefore, we intend to maintain the level of reimbursement that we believe is appropriate for our state.”⁴

- Retail prices do not account for the services associated with delivering DMEPOS items to Medicare beneficiaries. The service levels for retail or internet suppliers are extremely low or nonexistent when compared to those of Medicare suppliers. Medicare suppliers provide many additional services as part of delivering items to a beneficiary including patient education, clinical monitoring and care management. Medicare suppliers are required to meet twenty-one supplier standards, which include requiring a supplier to deliver items to a Medicare beneficiary, while retail customers must pick-up their items. These additional costs are not accounted for in the OIG report. Importantly, however, even considering the disparity in services levels between Medicare DMEPOS suppliers and retail establishments, the OIG found that the Medicare median is actually lower than the retail median for six of the sixteen items examined, with an additional four items having only a nominal price discrepancy.
- The OIG’s comparison of Medicare payment to the Federal Employees Health Benefits Plan (FEHB) is flawed because it compares two drastically different health care delivery models. FEHB is a health insurance program that includes many managed care companies. Managed care entities typically contract with suppliers for negotiated rates and guarantee a certain number of enrollees in return for the contracted rate. The administrative burden of servicing managed care enrollees is lower than dealing with the Medicare program. Generally, enrollees in these kinds of plans have more limited choices of suppliers than do Medicare beneficiaries. Managed care companies offer streamlined processes like prior approval which reduces the days sales outstanding, and the burdens of certifying medical necessity and collecting reimbursement.

Neither Competitive Bidding nor Inherent Reasonableness are Viable Payment Methodologies for the Medicare Program

The OIG has advocated the use of competitive bidding or inherent reasonableness as a method for reducing the prices that Medicare pays for certain DMEPOS items. Neither of these methodologies, however, accurately account for the full range of services associated with delivering the items to Medicare beneficiaries. In addition, both payment methodologies have serious structural and procedural flaws which would need to be addressed prior to CMS implementation.

The competitive bidding demonstration prices are a result of an artificially manipulated marketplace and therefore do not accurately reflect DMEPOS payment amounts that will sustain the level of services currently given Medicare beneficiaries. Although the four items analyzed

⁴ Department of Health and Human Services Office of Inspector General, Review of Medicaid Payment Amounts for Oxygen Related Durable Medical Equipment And Supplies, Wisconsin Department of Health and Family Services, Madison Wisconsin, October 2001; A-05-01-00031, (OIG Study).

by the OIG that were subject to the competitive bidding demonstrations achieved savings, it is too soon to fully understand the effect that these reductions will have on beneficiary access to critical services and choice of products. Competitive bidding may significantly reduce the services available to Medicare beneficiaries in the demonstration area. In fact, even CMS' in its January 2001 report "*Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS, First Year Annual Evaluation Report*" acknowledged that "[a]lthough we have learned a number of lessons from the evaluation so far, we caution that it is premature to make final conclusions about the long-term impact of the demonstration on many of the evaluation issues."

It is premature to make any economic assumptions based on the minimal amount of data coming out of the limited demonstration project. The costs of administering a national competitive bidding program are likely to offset any savings to the program. In addition to the reduction in services, competitive bidding would result in the elimination of small DMEPOS providers. This will result in a dearth of bidders when it is time to update or renew the bidding process. As a result, bid prices are likely to rise and patient choice is likely to diminish as more suppliers are eliminated.

CMS' use of IR authority is equally ill-advised given the serious procedural missteps in implementing the authority. CMS published an interim final rule with comment period in January 1998 implementing the authority granted in the Balanced Budget Act of 1997 (BBA 97). CMS did not respond to any of the comments submitted. Later that year, CMS issued a proposal to cut payments for eight groups of products. CMS issued another proposal for an additional round of cuts in August of 1999. Congress subsequently suspended CMS' IR authority pending a GAO study on the issue and the publication of a final rule.

The GAO report raised serious shortcomings regarding CMS' use of its inherent reasonableness authority including that CMS' data collection was not consistent and did not set out sufficient criteria. Because of the considerable amount of time that has passed since the initial rule was released and CMS' failure to respond to the comments submitted pursuant to the interim final rule, CMS should release a new inherent reasonableness rule for comment to allow a fair and full administrative process. In addition, prior to using inherent reasonableness, CMS needs to develop a process to ensure that any data used is statistically valid market data, develop a sound methodology and ensure an appeal mechanism for review.

Conclusion

In conclusion, Medicare payments should not and cannot be compared to the payments of the Department of Veterans Affairs, retail establishments or other private or public insurance programs because of the disparities inherent in the different health care delivery models. CMS should not use competitive bidding or inherent reasonableness to adjust payments until the procedural flaws in those methodologies are addressed.