



*National Association for the  
Support of Long Term Care*

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**STATEMENT OF THE  
NATIONAL ASSOCIATION FOR THE SUPPORT OF  
LONG TERM CARE (NASL)**

**HEARING ON THE DURABLE MEDICAL EQUIPMENT,  
PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)  
COMPETITIVE BIDDING PROGRAM**

**SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
UNITED STATES HOUSE OF REPRESENTATIVES**

**WEDNESDAY, MAY 9, 2012**

The National Association for the Support of Long Term Care (NASL) submits this statement to the House Ways & Means Subcommittee on Health for its May 9, 2012 hearing on the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program.

NASL represents providers and suppliers of products, medical supplies, diagnostic testing, professional services, therapy, and information systems for the long-term and post-acute care (LTPAC) industry, as well as LTPAC providers. NASL members include suppliers and manufacturers of durable medical equipment, prosthetics, orthotics and enteral nutrition, providers of physical, occupational, respiratory and speech-language pathology therapies, and health information systems developers.

Simply stated, NASL remains concerned that the Medicare competitive bidding program needlessly forces quality suppliers out of the Medicare program. It is poorly structured and, we believe, ultimately is destined to fail, thus creating serious access and quality issues for Medicare beneficiaries in need of DMEPOS products and services. Briefly, our principal concerns are the following:

- Under the current competitive bidding system, 50% of the “winning” bidders must accept payment levels that are below their bids, which is directly contrary to the basic rules of competitive bidding programs conducted elsewhere in the federal government. Thus, the Centers for Medicare & Medicaid Services’ (CMS’) competitive bidding program does not accurately reflect the market for a particular product category in a particular geographic area. Despite the description of the program as market-based, it really is nothing more than an arbitrary fee schedule that is applied to a reduced number of participating DMEPOS suppliers.
- The combination of allowing non-binding bids and inviting inexperienced suppliers to bid for the contracts has resulted in further distortions of the market, which is only accentuated when some of the lowest bidders walked away from the program but their bids still influenced the competitive bidding payment amounts.
- CMS has not made public the level of information necessary to gauge how successful the competitive bidding program really is in terms of patient access to quality care. For example, CMS has not responded

to the request of the Program Advisory and Oversight Committee (PAOC) for information in 2011 that would enable the PAOC to assess the impact of the competitive bidding program on beneficiaries and suppliers. Preliminary analyses performed by outside economists have at least raised the question that the reduction in utilization of DMEPOS products and services in the competitive bidding areas may be adversely affecting Medicare beneficiaries' access to medically necessary care. Round Two of the program, which is a ten-fold increase in the scope of the competitive bidding program, should not be undertaken until CMS demonstrates that patient access to care has not been compromised.

In addition to these basic concerns that are shared by virtually all DMEPOS suppliers, NASL wishes to raise particular issues that result from the application of the competitive bidding program to products provided in nursing facilities. One of the product categories that was included in Round One and expected to be in Round Two of the competitive bidding program, enteral nutrition, is primarily provided to residents of nursing facilities. This presents issues that go far beyond the scope of the competitive bidding program, as explained below.

Enteral nutrition involves the provision of nutrients by tube into a patient's stomach or intestine. It is prescribed by physicians for patients whose lower gastrointestinal tract functions normally but who are unable to swallow, who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth. Medicare Part B covers enteral nutrition formulas, supplies and equipment under the prosthetic device benefit when enteral nutrition is necessary for the patient to maintain weight and strength commensurate with his or her general condition.

It is noteworthy that enteral nutrition was not tested successfully during the two demonstration projects that preceded the enactment of the Medicare Modernization Act of 2003, which created the competitive bidding program for DMEPOS items and services. In fact, enteral nutrition was removed from the Polk County, Florida demonstration, in large part, we believe, because most enteral patients in that county resided in nursing facilities. This created complications that CMS did not want to address at that time.

Nursing facilities have a special relationship with their residents. In most instances, the nursing facility is the resident's home. The nursing facilities

are responsible for providing complex nursing and rehabilitative therapy services involving an array of clinicians, providers and suppliers to meet patient health care needs, and the facilities are held accountable for the quality of these services. Nursing facilities must meet detailed conditions of participation to participate in the Medicare and Medicaid programs as well as a wide array of additional federal and state requirements regarding patient safety and quality of care. Because of their multiple responsibilities in this regard, nursing facilities traditionally have established long-standing relationships with selected suppliers based on experience, and suppliers' understanding of the fragile and medically complex patient that relies on the nursing facility for care.

For these reasons, many nursing facilities were extremely concerned that the competitive bidding program would force them to admit unfamiliar suppliers into their facilities to provide services, supplies and equipment to their residents. NASL agrees with nursing facilities on this point – that the facilities must be able to select the suppliers that the facilities believe can best enable them to meet resident needs and comply with applicable standards. Unfortunately, the competitive bidding program has interfered with their ability to make these decisions regarding the enteral nutrition needs of their residents, and has disrupted ongoing relationships that had worked to the benefit of their residents. The fact that grandfathering (i.e., permitting non-winning bidders to continue to provide care to their current patients if they accept the competitively bid rates) was not extended to enteral nutrition ensured that every nursing facility that did not win a bid, or where the particular nursing facility's enteral nutrition supplier did not win the bid, had to find a new enteral nutrition supplier.

In addition, the provision of enteral nutrition therapy in nursing facilities differs from the provision of therapy in patients' homes. Residents in nursing facilities often are more impaired than home care patients and require a different regimen of care. Enteral patients in nursing facilities have dietary needs that change more frequently than most home care patients, thus requiring an enteral nutrition supplier that can readily address their special needs. An enteral supplier that has had no experience working with the complex medical needs of nursing facility residents may not be an adequate replacement for a supplier that has had years of such experience.

We do not believe there has been adequate scrutiny of the application of the competitive bidding program to nursing facility residents. We urge

Congress to require CMS to provide the data to the Government Accountability Office for its required analysis of the competitive bidding program, and the public, to address the following issues:

- Changes in treatment patterns of enteral nutrition patients in nursing facilities in competitive bidding areas, and whether the use of new enteral nutrition suppliers has increased nursing facility costs for the care of their enteral nutrition patients;
- Observations from nursing facilities' clinicians as to any diminution in quality of enteral nutrition therapy provided to their residents;
- Incidence of re-hospitalization of nursing facility residents in need of enteral nutrition in competitive bidding areas in 2011, compared to the re-hospitalization rates in those areas in 2010; and
- Whether the new enteral nutrition suppliers providing enteral nutrition to nursing facility residents had previous experience in treating nursing facility residents.

In addition, we request that Congress require CMS to grandfather all patients and products involved in the competitive bidding program in any future expansion or extension of the program.

#### Additional Recommendations

We join with numerous other commenters in advocating for the adoption of the concept of the Market Pricing Program developed by the DMEPOS industry. We believe that better definitions of the professional services and related costs for the provision of DMEPOS, along with a fairer and more reasonable bidding regimen that will accurately capture market prices, will be a dramatic improvement over the current competitive bidding program.

If Congress decides to continue with the current competitive bidding program, then we urge Congress to correct the deficiencies in the program we have identified in this statement. In addition, we urge Congress to modify the planned product categories for the Round One Re-Compete, scheduled to go into effect in 2014 for the original nine competitive bidding areas. CMS intends to group certain unrelated product categories into larger categories. For example, CMS intends to create a new "General Home Equipment and Related Supplies and Accessories" category that will encompass hospital beds and related accessories, group 1 and 2 support services, transcutaneous electrical nerve stimulation devices, commode

chairs, patient lifts and seat lifts. Many suppliers provide some but not all of these items. As a result, this will lead to several disturbing problems:

- This approach unfairly favors large, “one-stop shop” operations, which ultimately will be anti-competitive.
- Specialty or niche suppliers that have significant experience and enviable track records for quality for one or several of the items will be at a distinct disadvantage in the bidding for all of the items in this category.
- To survive in this bidding process, small or niche suppliers will have to increase the degree of subcontracting to cover the wide array of products in the category. Subcontracting increases the possibility of patient and provider confusion, disruptions in care and similar issues.
- For those suppliers that choose not to subcontract to provide the full array of items in this category, they must attempt to become proficient and efficient in product areas with which they do not have experience. We believe the Medicare program should be providing incentives to suppliers to provide services and products in areas where they excel, instead of encouraging suppliers to experiment in other product areas.

The DMEPOS competitive bidding program must be designed to still produce savings for the Medicare program, and not diminish the quality of products, supplies and services for the patient. Therefore, we thank the committee for bringing attention to the issue by holding this hearing and urge Congress to complete a full analysis of the competitive bidding program before it expands the program to 91 Metropolitan Statistical Areas. NASL, is an organization that represents suppliers and manufacturers of durable medical equipment, prosthetics, orthotics and enteral nutrition, stands ready to be a resource, as you carry out the important work relating to the competitive bidding program.