



# NAMES

National Association for  
Medical Equipment Services

## Amendment to Section 4118 of S.1757/H.R. 3600

### Proposed Amendment

Section 4118 is amended by striking paragraphs (1), (2) and (3) of Subsection (c) of proposed Section 1847, and Subsection (c) of proposed Section 1847 should read as follows:

"(c). SERVICES DESCRIBED -- The items and services to which the provisions of this section shall apply are magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of such tests and scans."

### Explanation of Amendment

There are, at the present time, no clear and commonly accepted quality standards of care for the provision of oxygen and oxygen equipment. In addition, the Medicare program has not developed quality standards for the home medical equipment (HME) services industry. As a result, there is a wide variety in the levels of care provided by oxygen suppliers across the country. Under these circumstances, competitive bidding would place Medicare beneficiaries at risk that their oxygen suppliers will be selected for them on the sole basis of cost, to the exclusion of quality concerns. This would be an unwise policy. Thus, the amendment would delete the application of the competitive bidding requirements to oxygen and oxygen equipment.

In addition, the amendment would delete the authority granted to the Secretary to use competitive bidding for additional items and services whenever the Secretary determines that it would be "appropriate and cost-effective." This provision would enable the Secretary to erase payment policies that have been developed over a number of years, thus undoing all of the previous efforts by Congress in a particular area, simply because the Secretary concludes that it would be "appropriate and cost-effective" to do so. This would be an enormous grant of authority to the Secretary, without any limits or guidelines set by Congress. This would be an unwise policy.

If Congress wishes for a competitive bidding process to be applied to a particular area, then Congress should strictly specify that area after due consideration, serious discussions with industry, careful study and successful demonstration projects, and never abdicate this role to an administrative agency.



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## POSITION PAPER

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# Competitive bidding

### Background

The Clinton Administration submitted to Congress in October proposed legislation to reform the nation's health care system. Included in the "Health Security Act" is a provision to implement competitive bidding for oxygen, oxygen equipment and other items and services where competitive bidding may be determined by the Department of Health and Human Services to be cost-effective.

### Status

The "Health Security Act" includes a provision requiring "competitive bidding" for oxygen, oxygen equipment and "such other items and services as determined by the Secretary of Health and Human Services." NAMES has a number of specific objections to competitive bidding for the HME services industry. However, our major objection can be summed up simply: **Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to Americans.** Such a radical restructuring of how HME is provided virtually would ensure that there would be a serious deterioration in the quality of HME services. In fact, in instances where competitive bidding already has been attempted, some suppliers submitted unreasonably low bids to win the contract but then could not cover the costs of providing the services and were forced to cut corners — with horrible results.

The following points illustrate extremely serious problems inherent with competitive bidding for home medical equipment (HME):

- It is very hard to design and administer any competitive bidding process without damaging the market. If a winning bid is awarded solely to one provider, within a given "service area" as proposed by the Clinton Administration, this certainly will drive many small companies out of business; the sole winner in future years thus would have a considerably reduced level of competition.
- Competitive bidding for certain selected HME items has been tried and subsequently abandoned in a number of states. There are enormous complexities involved in dividing the entire nation into multiple and reasonable service areas. Few suppliers provide all possible HME services, so it would be necessary to define different service areas for different kinds of equipment. It currently takes on

average 90 days for HME suppliers to get paid. As a result, it is highly unlikely any company would have the capital necessary to expand into new services in order to take on large competitively bid contracts.

- With any competitive bidding system, the first issue to consider must be a determination of what level of service provided by HME suppliers the government is willing to pay. Otherwise, the government should be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear. Competitive bidding is known to work poorly both for the Defense Department and the VA, places where it already is used on a large scale similar to what Medicare would require.
- VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA contract winners. Medicare would have to expect similar, if not greater, problems in access and quality. The VA, once acquiring a signed contract in certain states, has monitored the provider for provisions of services only to find they have no awareness of home oxygen and HME items in the areas of: quality; appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment.

### Position

NAMES strongly opposes competitive bidding in general for the HME services industry. Competitive bidding will not ensure quality HME services and could curtail access of HME to all Americans

### Action Plan

NAMES will continue to work closely with the Administration and Congress to advocate the HME services industry's position, noted above. NAMES also will urge Congress that, prior to authorizing any competitive bidding for HME, Congress closely scrutinize the prior mistakes inherent in other competitive bidding projects to date, consult closely with the HME services industry, thoroughly demonstrate the concept in select areas for a minimum of four years and have the results evaluated thoroughly by independent outside parties before proceeding further with consideration of competitive bidding proposals.



## HOME MEDICAL EQUIPMENT SERVICES AND NATIONAL HEALTH CARE REFORM

### INTRODUCTION

Home medical equipment (HME) services are a vital component of our nation's national health care system. HME is demonstrably cost-effective. Home care, including HME, is projected to increase in use in the coming decades. Meanwhile, major insurance underwriters have begun to recognize the growing trend that contributes to making home care using HME services a viable alternative to more costly institutional care. Finally, persons with disabilities and the elderly far prefer to recuperate from an illness or injury at home.

### RECOMMENDATIONS

NAMES recommends that Congress adopt the following principles during its debate on national health care reform:

- Ensure that HME and HME services are included in the basic benefits package, as currently covered in the Health Security Act;
- Include coverage of and payment for "custom" home medical equipment devices and rehabilitation technology, particularly motorized wheelchairs and seating systems (also currently covered in the Health Security Act);
- Remove the provision in the Health Security Act that requires competitive bidding for oxygen and oxygen equipment and "other services" under Medicare. Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to persons with disabilities and older Americans;
- Allow consumers the freedom to choose their health care providers (including HME suppliers) and not permit health care plans to select sole source providers; and
- Ensure that "quality of care" measures encompass existing HME industry practices, including: the service component; customization; patient/client satisfaction; and success of outcomes.

Comprehensive health care reform should establish no impediments either to the provision of HME services or to the enhancement of care in the home and other non-institutional settings.

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Comprehensive health care reform should establish no impediments either to the provision of HME services or to the enhancement of care in the home and other non-institutional settings. As such, NAMES recommends that Congress adopt the following principles during its debate on national health care reform:

1. **Ensure that HME and HME services are included in the basic benefits package, as currently covered in the Health Security Act:**
  - 87% of federally qualified HMOs in this country include HME services as a standard benefit in their health care packages;
  - Most of the top twenty major private health insurance providers also currently offer HME as a basic benefit in their major medical indemnity plans; and
  - The Consortium for Citizens with Disabilities (CCD), representing over 100 disability organizations, strongly supports the inclusion of HME in the basic benefits package.
2. **Include coverage of and payment for "custom" home medical equipment devices and rehabilitation technology, particularly motorized wheelchairs and seating systems (also currently covered in the Health Security Act):**
  - Customized rehabilitation/assistive technology is as essential for persons with disabilities as properly fitting a prosthetic device is for an amputee or prescribing the correct drug medication dosage is for a specific illness;
  - Custom devices prevent deterioration and complications in the health status of patients; and
  - Restrictions on customization could lead to aggravation an existing disability.
3. **Remove the provision in the Health Security Act that requires competitive bidding for oxygen and oxygen equipment and "other services" under Medicare. Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to persons with disabilities and older Americans:**
  - Between 1985 and 1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report summary stated that:  
"Competitive bidding processes per se will not necessarily result in lower Medicare costs...;"
  - Competitive bidding for certain HME items has been tried and subsequently abandoned in a number of states. Enormous complexities would arise in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services;
  - The General Accounting Office (GAO) in 1986 studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts and concluded that HCFA lost money on four of them; and
  - The government should be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear under competitive bidding.
4. **Allow consumers the freedom to choose their health care providers (including HME suppliers) and not permit health care plans to select just sole source providers for them:**
  - NAMES already is beginning to see situations develop where consumer choice is being severely limited because some HMOs contract only with one HME supplier. Our concern is that reducing the number of providers in a given field will result in decreased competition, eventually driving up prices, while diminishing quality of care; and
  - No single provider can adequately cover as large a geographical and populated area as envisioned in the Clinton plan.
  - Final health care reform legislation should provide incentives for health plans to contract with as many providers as necessary to meet the needs of the community. At the very least, there should not be any disincentives in the system to allowing full provider participation. As well, administrative simplification of forms and the processing of reimbursement claims would help eliminate some of these disincentives.
5. **Ensure that "quality of care" is measured in a way that is consistent with existing HME industry practices. This would include: the service component; customization; patient/client satisfaction; and success of outcomes:**
  - Only tested methods of quality assurance and quality improvement be used. These methods might include requiring a full range of HME services available, outcome measures, as well as patient satisfaction. Providers and consumers alike should have substantial input on determining or defining quality.

Calendar No. 335

103d CONGRESS  
1ST SESSION

S. 1757

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20 (legislative day, NOVEMBER 2), 1993

Mr. MITCHELL (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. AKAKA, Mr. BAUCUS, Mrs. BOXER, Mr. BUMPERS, Mr. CAMPBELL, Mr. CONRAD, Mr. DODD, Mrs. FEINSTEIN, Mr. GLENN, Mr. GRAHAM, Mr. HARKIN, Mr. INOUE, Mr. JEFFORDS, Mr. LEAHY, Mr. LEVIN, Mr. MATHEWS, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mrs. MURRAY, Mr. PELL, Mr. PRYOR, Mr. REID, Mr. SIMON, and Mr. WOFFORD) (by request) introduced the following bill; which was read the first time

NOVEMBER 22, 1993

Read the second time and placed on the calendar

7 SEC. 4118. APPLICATION OF COMPETITIVE ACQUISITION  
8 PROCESS FOR PART B ITEMS AND SERVICES.

9 (a) GENERAL RULE.—Part B of title XVIII of the  
10 Social Security Act is amended by inserting after section  
11 1846 the following:

12 "COMPETITION ACQUISITION FOR ITEMS AND SERVICES  
13 "SEC. 1847. (a) ESTABLISHMENT OF BIDDING  
14 AREAS.—

15 "(1) IN GENERAL.—The Secretary shall estab-  
16 lish competitive acquisition areas for the purpose of  
17 awarding a contract or contracts for the furnishing  
18 under this part of the items and services described  
19 in subsection (c) on or after January 1, 1995. The  
20 Secretary may establish different competitive acqui-  
21 sition areas under this subsection for different class-  
22 es of items and services under this part.

23 "(2) CRITERIA FOR ESTABLISHMENT.—The  
24 competitive acquisition areas established under para-  
25 graph (1) shall—

1           “(A) initially be, or be within, metropolitan  
2           statistical areas; and

3           “(B) be chosen based on the availability  
4           and accessibility of suppliers and the probable  
5           savings to be realized by the use of competitive  
6           bidding in the furnishing of items and services  
7           in the area.

8           “(b) AWARDING OF CONTRACTS IN AREAS.—

9           “(1) IN GENERAL.—The Secretary shall con-  
10          duct a competition among individuals and entities  
11          supplying items and services under this part for  
12          each competitive acquisition area established under  
13          subsection (a) for each class of items and services.

14          “(2) CONDITIONS FOR AWARDING CONTRACT.—

15          The Secretary may not award a contract to any indi-  
16          vidual or entity under the competition conducted  
17          pursuant to paragraph (1) to furnish an item or  
18          service under this part unless the Secretary finds  
19          that the individual or entity—

20                 “(A) meets quality standards specified by  
21                 the Secretary for the furnishing of such item or  
22                 service; and

23                 “(B) offers to furnish a total quantity of  
24                 such item or service that is sufficient to meet

1           the expected need within the competitive acqui-  
2           sition area.

3           “(3) CONTENTS OF CONTRACT.—A contract en-  
4           tered into with an individual or entity under the  
5           competition conducted pursuant to paragraph (1)  
6           shall specify (for all of the items and services within  
7           a class)—

8                 “(A) the quantity of items and services the  
9                 entity shall provide; and

10                “(B) such other terms and conditions as  
11                the Secretary may require.

12          “(c) SERVICES DESCRIBED.—The items and services  
13          to which the provisions of this section shall apply are as  
14          follows:

15                “(1) Magnetic resonance imaging tests and  
16                computerized axial tomography scans, including a  
17                physician's interpretation of the results of such tests  
18                and scans.

19                “(2) Oxygen and oxygen equipment.

20                “(3) Such other items and services for which  
21                the Secretary determines that the use of competitive  
22                acquisition under this section will be appropriate and  
23                cost-effective.”.

24          (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
25          THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)

1 (42 U.S.C. 1395y(a)), as amended by section 4034(b)(4),  
2 is amended—

3 (1) by striking “or” at the end of paragraph  
4 (14);

5 (2) by striking the period at the end of para-  
6 graph (15) and inserting “; or”; and

7 (3) by inserting after paragraph (15) the fol-  
8 lowing new paragraph:

9 “(16) where such expenses are for an item or  
10 service furnished in a competitive acquisition area  
11 (as established by the Secretary under section  
12 1847(a)) by an individual or entity other than the  
13 supplier with whom the Secretary has entered into  
14 a contract under section 1847(b) for the furnishing  
15 of such item or service in that area, unless the Sec-  
16 retary finds that such expenses were incurred in a  
17 case of urgent need.”

18 (c) REDUCTION IN PAYMENT AMOUNTS IF COMPETI-  
19 TIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUC-  
20 TION IN PAYMENTS.—Notwithstanding any other provi-  
21 sion of title XVIII of the Social Security Act, if the estab-  
22 lishment of competitive acquisition areas under section  
23 1847 of such Act (as added by subsection (a)) and the  
24 limitation of coverage for items and services under part  
25 B of such title to items and services furnished by providers

1 with competitive acquisition contracts under such section  
2 does not result in a reduction of at least 10 percent in  
3 the projected payment amount that would have applied to  
4 the item or service under part B if the item or service  
5 had not been furnished through competitive acquisition  
6 under such section, the Secretary shall reduce the pay-  
7 ment amount by such percentage as the Secretary deter-  
8 mines necessary to result in such a reduction.

9 (d) EFFECTIVE DATE.—The amendments made by  
10 this section shall apply to items and services furnished  
11 under part B of title XVIII of the Social Security Act on  
12 or after January 1, 1995.

13 **SEC. 4119. APPLICATION OF COMPETITIVE ACQUISITION**  
14 **PROCEDURES FOR LABORATORY SERVICES.**

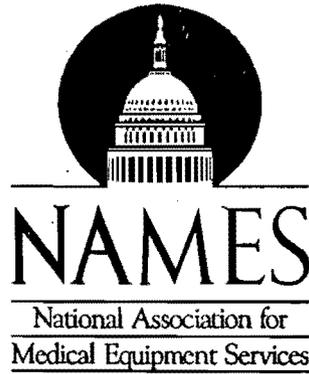
15 (a) IN GENERAL.—Section 1847(c), as added by sec-  
16 tion 4118, is amended—

17 (1) by redesignating paragraph (4) as para-  
18 graph (5); and

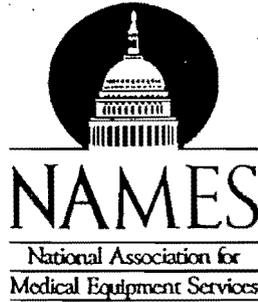
19 (2) by inserting after paragraph (3) the follow-  
20 ing new paragraph:

21 “(4) Clinical diagnostic laboratory tests.”

22 (b) REDUCTION IN FEE SCHEDULE AMOUNTS IF  
23 COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAV-  
24 INGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended  
25 by adding at the end the following new paragraph:



**Statement**  
**of the**  
**National Association for Medical Equipment Services**  
**on**  
**“Meeting the Needs of Americans with Disabilities**  
**under the Health Security Act”**  
**presented to the**  
**Senate Labor and Human Resources Committee**  
**Hearing**  
**of**  
**Tuesday, February 22, 1994**



## Executive Summary

NAMES and the home medical equipment (HME) services industry applaud the Clinton Administration and Congress for tackling the difficult problem of trying to reform our nation's health care system and for placing health care reform at the top of our nation's agenda.

The Administration properly included HME as part of the "standard benefits package" in its Health Security Act. This should be no great surprise, since home care including HME services is demonstrably cost-effective — even more so than similar care provided in a more costly institutional setting. Equally important, nearly 3 out of 4 older Americans would rather provide care for a disabled, frail or elderly relative or friend at home, rather than have to admit that person to a nursing home.

However, the following key concerns in the Health Security Act must be addressed:

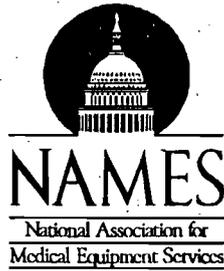
1. Competitive bidding for oxygen and oxygen equipment and "other items" under Medicare — Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to persons with disabilities and older Americans.
2. "Freedom of choice" guarantees — All Americans must be able to select their health care providers, including HME suppliers. Quality should be measured in a way that is consistent with existing HME services industry practices. This would include: the service component; customization; patient/client satisfaction; and success of outcomes.

The Health Security Act requires competitive bidding under Medicare for certain HME services. Competitive bidding for HME already has been tried and subsequently abandoned in a number of states, undoubtedly due to severe implementation problems. Even more enormous complexities would arise if the entire nation were divided into multiple and reasonable service areas, as few suppliers provide all possible HME services. Persons with disabilities and older Americans living in rural communities across America in particular will be affected.

Especially important, all Americans should have freedom to choose their health care providers. The Administration's proposal encourages health plans to contract with only one provider in a given field. Such a practice would limit the choices of available providers from whom consumers can select.

The Administration's proposal would allow consumers to choose health plans based on price and quality. Because quality measurement and determination are such important issues, only tested methods of quality improvement should be used.

Finally, comprehensive health care reform should establish no impediments to either the provision of HME services or the enhancement of care in the home and other non-institutional settings.



Statement  
of the  
National Association for Medical Equipment Services  
on  
“Meeting the Needs of Americans with Disabilities  
under the Health Security Act”  
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Hearing  
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Tuesday, February 22, 1994

The National Association for Medical Equipment Services (NAMES) is pleased to comment on the “Health Security Act.” NAMES represents over 2,000 home medical equipment (HME) suppliers who provide quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Administration for including HME services and custom devices as part of its “standard benefits package.” HME is demonstrably cost-effective and persons with disabilities and the elderly far prefer to recuperate from an illness or injury at home. In addition, NAMES is extremely pleased that the Health Security Act includes a long-term care component that allows individuals with disabilities and older Americans the opportunity to further utilize HME equipment and services.

Several aspects of the Clinton plan, however, cause great concern for the HME services industry. The following issues in the Health Security Act must be addressed:

### **1. Competitive Bidding**

Section 4118 of the Health Security Act seeks to implement competitive bidding for oxygen and oxygen equipment and “such other items and services” as determined by the Secretary of the Department of Health

and Human Services. This provision is part of the \$238 billion in Medicare and Medicaid cuts over five years that will help pay for the Administration's proposal. The goal of maintaining and improving quality health care for millions of Americans will not be advanced by competitive bidding for home medical equipment or rehabilitative/assistive technology. In fact, our experience demonstrates that competitive bidding will reduce the provision of quality HME services for persons with disabilities and older Americans.

The provision of HME for persons with disabilities and older Americans requires an extensive services component. Providers of HME deliver much more than just the equipment — the more critical component of HME includes the services rendered to the individual users, such as: setting up the equipment; explaining how it operates; properly fitting a wheelchair's seating system to accommodate the user's particular disability; and maintaining it. Experience indicates that, where previously implemented, competitive bidding systems have not guaranteed the maintenance of such high levels of quality service. NAMES strongly believes that competitive bidding will *not* ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans.

**(a) The Service Component**

With any competitive bidding system, the first issue to consider must be a determination of what level of services provided by HME suppliers the government is willing to purchase. Congress must be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear entirely with competitive bidding for home medical equipment. As but one example of how competitive bidding has not worked well, suppliers in Minnesota have expressed serious concern about numerous service-related problems associated with the provisions of HME by the Minnesota Medical Assistance Contracted Providers, a group of companies that have been awarded Medicaid contracts with the state. Some problems that have developed include:

- Inadequate patient education and training on equipment;
- Poor professional follow-up services to determine if the patient is properly using the equipment;
- Irregular equipment checks to determine if the equipment is properly working; and
- Contracts that allow a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and setup.

Americans with disabilities and the elderly could suffer significantly under competitive bidding because access to the services inherent in providing the custom, highly specialized equipment they require likely will

diminish. NAMES estimates that the small percentage of HME suppliers who could remain in business under this type of structure would not be able to provide high cost, low margin and highly serviced equipment to all corners of the country.

An HME provider in Minnesota services approximately 100 oxygen patients, with 90 of them being Medicare beneficiaries. Typically, the company provides an average of three after hours (evenings and weekends) calls per week to provide emergency service to the patients or new setups. If these patients were not serviced adequately and on a timely basis, costly hospitalizations would result. Often, new orders for oxygen in the home are initiated from an urgent care clinic or hospital emergency room, thereby avoiding hospital admission. Under competitive bidding, a rapid response time by a limited pool of providers would not be possible, leading to additional and more costly hospital admissions.

One patient's story exemplifies this problem: Charlotte is an elderly woman on Medicare. Both her body and her mind are deteriorating. Stricken with emphysema, Charlotte is dependent on the oxygen fed to her through a concentrator. She also suffers from frequent memory lapses. Often, Charlotte forgets everything about her life-sustaining equipment — everything but the phone number of her medical equipment supplier in Minnesota. Sometimes two or three times a week, Charlotte experiences a "medical equipment crisis," having forgotten how to operate her oxygen concentrator. Fortunately, these emergencies are remedied quickly by her medical equipment provider, located only two miles from her house. Within minutes, Charlotte's oxygen flows again. Under a competitive bidding scenario, Charlotte's provider could be located hours away. The costs of Charlotte's crises would be much greater — exorbitant hospital admission fees or, worse yet, death.

#### **(b) Complexity of Implementing Competitive Bidding**

Competitive bidding for certain HME items already has been tried and subsequently abandoned in a number of states. Even more enormous complexities would arise in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. The following consequences likely could result:

- Rural communities across America would be most affected, as beneficiaries would not have access to hundreds of medical equipment and supply items;
- Successful bidders for oxygen and other major products would not be able to provide reasonable coverage for the delivery of the full spectrum of HME items and services to all of the areas and

regions throughout America; and

- Successful bidders would have to deliver a significant portion of the required equipment. Smaller companies that provide and service less costly and lower volume items simply would not be able to continue to provide delivery of these items. They subsequently could cease to exist. Severe delivery delays for equipment and services by larger companies that may maintain their presence through the bid would occur because of the high cost of delivering HME beyond reasonable distances, across urban areas and throughout rural areas. Thus, hospital discharges to the home would be delayed and hospital admissions would increase as patients wait for the required equipment to be cared for at home.

**(c) Cost of Competitive Bidding**

Under competitive bidding structures that currently exist for oxygen in the Veterans Administration (VA), equipment delivery times range from 24 hours to 72 hours from the time an equipment order is initiated. This significant delay results from permitting the bidder who has the contract enough time to cover a large geographic area and be as efficient as possible in order to stay in business under the lower competitive bidding rates.

- With delivery delays, we expect to see an increase of overall health care delivery costs. Patients will experience delays in discharge (which will severely disrupt the current DRG structure under Medicare Part A), while waiting for service.
- Service levels will deteriorate significantly. Follow-up visits by health professionals that facilitate ongoing and thorough patient/physician/provider interaction, patient/caregiver education and monitoring of adherence to physician orders will be eliminated or considerably reduced.
- Emergency service (24 hours per day) will be compromised because of the distance that companies typically travel to care for patients under a competitive bidding structure. Routine maintenance checks of equipment servicing will be cut back due to cost constraints, causing concern for patient safety.
- If only one readmission for acute exacerbation of the pulmonary condition known as "COPD" occurs, which otherwise could have been avoided by providing the high level of in-home service that exists today, the cost of that Medicare admission to the federal government will exceed the savings achieved under competitive bidding for that individual patient for several years.

Competitive bidding is known to work poorly both for the Defense Department and the VA, where this technique already is used on a large scale, similar to what Medicare would require. Some VA hospitals have experienced quality deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), due on average to the poor quality of services provided by VA competitive bidding contract winners. The VA, once acquiring a signed contract in certain states, has monitored providers for provision of services, only to find they have little awareness of appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment. Under the

Health Security Act's competitive bidding proposals, similar, if not greater, problems in access and quality would be expected.

British Columbia, Canada, has had a competitive bidding process for HME services in place since November 1991. There, the government uses a scheme of establishing a "preferred" provider based on the lowest bid and up to 2 "approved" providers based on the next lowest bid in each health unit (7 units in British Columbia). Typically, this system allows for: a delay as long as *48 hours* to set up new patients, from time of initial order; a lengthy three-year bid period with the government option to renew every year if the provider is not performing based on confirmed complaints; concentrators, liquid oxygen systems, portable systems and contents to be bid and paid for separately, with contents based on actual usage; government mandates on patient follow-ups/assessments done only every *6 months* as a minimum; government mandates that require concentrators to be maintained at only a minimum of every three months. This system has experienced an overall decline in service levels because patients have remained in hospitals longer. Service delays and hospital admissions more than likely have increased because of minimal patient/provider/physician interaction. Such minimal service levels are far from what current American practice allows and, we submit, are therefore unacceptable.

#### (d) Competitive Bidding Studies

In 1986, the General Accounting Office (GAO) studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts, conducted on an experimental basis for Medicare carriers and intermediaries. After examining seven of the contracts, GAO made the following observations:

- A major change in the method of contracting used in the Medicare program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program;
- The frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance; and
- There is potential for disrupted service.

GAO concluded that HCFA in fact lost money on four of the contracts (Medicare - Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 1986).

Although HCFA has studied and recommended the implementation of competitive bidding for many years, Congress repeatedly has wisely rejected the agency's proposals on this issue. Between 1985 and

1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report summary stated that:

**“Competitive bidding processes per se will not necessarily result in lower Medicare costs (service and administration) for DME or clinical laboratory services in comparison to other available reimbursement methods. The ability of competitive bidding to realize savings for Medicare, while safeguarding quality, depends critically on the design, implementation and subsequent administration of the bidding system adopted. This review of the empirical literature has raised a host of issues for DME and clinical laboratory competitive bidding demonstrations, while providing considerably fewer findings that can be put forward with confidence.”**

From these studies alone it is clear that competitive bidding on HME should not be an option for the Medicare program. NAMES does not oppose *competition* in the health care marketplace, provided that the quality of patient care and services are maintained. However, no data have been presented to indicate that inadequate competition exists today in the HME services marketplace. Indeed, the increasing number of new entrants indicates that competition is flourishing. Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact that such a system would have on persons with disabilities, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment and rehabilitation/assistive technology services.

## 2. Freedom of Choice

Especially important, all Americans should have freedom to choose their health care providers. Because the Health Security Act encourages health plans to operate as efficiently and cost-effectively as possible, health plans theoretically could contract with just one provider in a given field. Such a practice would limit the choices of available providers from among which consumers could select. HME suppliers from whom consumers already may have received prior care or whose companies are closer to home could be closed out.

There is general consensus that whatever shape health care reform takes, consumers and purchasers of health care should be permitted to exercise free choice based upon quality, cost and patient satisfaction. There can be no meaningful consumer choice, however, without market access by truly competing providers of care. NAMES already is beginning to see situations develop where consumer choice is being severely limited primarily because some HMOs will contract only with one HME supplier. Our concern is that reducing the number of providers in a given field will result in **decreased competition**, eventually driving up prices, while diminishing quality of care. No single provider can adequately cover as large a geographical

and populated area as envisioned in the Health Security Act. Suppliers vigorously oppose the concept of a competitive bidding system for HME items that essentially would lead to diminution of services and quality.

NAMES strongly supports the following “freedom of choice” principles:

- No provision in the final health care reform plan should be constructed to allow monopolization, attempted monopolization, conspiracy to monopolize or other restraint of trade prohibited under the existing antitrust laws;
- Any proposed “health plan” must select participating providers through a competitive process using objective criteria, including quality, price, services and patient satisfaction; and publish a description of any competitive selection process in advance to permit all interested providers a fair opportunity to participate;
- States may not limit or prohibit competition among providers to participate in a health plan by granting any antitrust exemption;
- Integrated health systems should be prohibited from acquiring or maintaining control of more than 20 percent (20%) of the business in a particular health care product and geographic market; and
- Providers seeking the protection of “safe zones” under the new Justice Department guidelines and Federal Trade Commission rules must publish a notice in a local newspaper describing the nature of the project.

NAMES recommends that the final health care reform legislation should provide incentives for health plans to contract with as many providers as necessary to meet the needs of the community. At the very least, there should not be any disincentives in the system to allowing full provider participation. As well, administrative simplification of forms and the processing of reimbursement claims would help eliminate some of these disincentives.

Finally, the Health Security Act would allow consumers to choose health plans based on price and quality. Because quality measurement and determination are such important issues, NAMES proposes that only tested methods of quality assurance and quality improvement be used. These methods might include requiring a full range of HME services available, outcome measures, as well as patient satisfaction monitoring. Providers and consumers alike should have substantial input on determining or defining quality.

## **Conclusion**

One solution to rising health care costs that emerges as an efficient, affordable and compassionate option is HME services as part of home care. HME suppliers meet the needs of a wide range of individuals who require medical equipment and services in their homes. Suppliers not only provide many of the more “traditional” items of equipment such as those envisioned when the Medicare Part B “DME” benefit was

first adopted as part of the Medicare law in 1965, but also provide a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, and advanced rehabilitation equipment and assistive technology. Comprehensive health care reform should establish no impediments to the use of home care and HME services that are currently available or to the enhancement of care in the home and other non-institutional settings.



**Testimony**

**of**

**Michael R. Tracey, President  
Hom-Ox-Equip Company**

**and**

**Representing the**

**National Association for Medical Equipment Services**

**on**

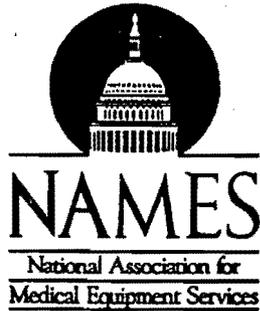
**Competitive Bidding**

**before the**

**Subcommittee on Health  
House Ways and Means Committee**

**Hearing  
of**

**Tuesday, November 23, 1993**



## Executive Summary

The Administration's "Health Security Act of 1993" seeks to implement competitive bidding for oxygen and oxygen equipment, parenteral and enteral nutrition (PEN) and other "such other items and services" as determined by the Secretary of the Department of Health and Human Services. As the President of a home medical equipment (HME) services company and the Minnesota Association of Home Medical Equipment Suppliers, I have witnessed first hand the negative anti-competitive effects of competitive bidding, as Minnesota's Medicaid Program currently allows for competitive bidding on wheelchairs and oxygen equipment. For that reason, I oppose competitive bidding for the HME services industry, as does NAMES.

Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans. A number of GAO and HCFA-initiated studies support this claim. Let me highlight a few of the problems that have been identified:

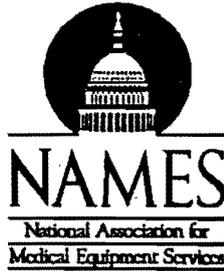
**Complexity of Implementing Competitive Bidding:** Competitive bidding for certain HME items has been tried and subsequently abandoned in a number of states, no doubt due to implementation problems. Imagine the enormous complexities involved in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. Rural communities across America will be particularly adversely affected by competitive bidding.

**Cost of Competitive Bidding:** Under competitive bidding structures for oxygen equipment that currently exist in the Veterans Administration (VA), equipment delivery time ranges from 24 hours to 72 hours from the time the order is initiated until it is delivered. This is necessary to allow the bidder, who now has the contract, time to service the large geographic area. With such delays, there will be an increase of overall health care delivery costs. Patients will experience delays in hospital discharges (which will severely disrupt the current DRG structure under Medicare Part A), while waiting for service.

**The Service Component:** In my home state, a number of service-related problems exist with companies that have been awarded Medicaid contracts with the state: (1) inadequate patient education and training on equipment; (2) poor professional follow-up services to determine if the patient is properly using the equipment; (3) irregular equipment checks to determine if the equipment is properly working; and (4) a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and set-up.

**Impact on Small HME Suppliers:** If a winning bid is awarded solely to one provider within a given "service area," as currently proposed by the Administration, this certainly will drive many small companies out of business. The sole winner in future years thus would have a considerably reduced level of competition — and considerably reduced choices for consumers in choosing an HME provider.

Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact we predict that such a system would have on patients, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment services.



**Testimony**  
**of**  
**Michael R. Tracey, President**  
**Hom-Ox-Equip Company**  
**and**  
**Representing the**  
**National Association for Medical Equipment Services**  
**on**  
**Competitive Bidding**  
**before the**  
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**Tuesday, November 23, 1993**

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today on behalf of the National Association for Medical Equipment Services (NAMES) to talk about the competitive bidding provisions contained in the "Health Security Act of 1993." NAMES represents over 2,000 home medical equipment (HME) suppliers, who provide quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Administration for including HME services and custom devices as part of its "standard benefits package" because HME is demonstrably cost-effective and consumers far prefer to recuperate from an illness or injury at home. But, as the health care reform debate advances, with the goal of maintaining and improving quality health care for millions of Americans,

NAMES believes Congress should not consider implementing competitive bidding for the HME services industry as proposed in the Administration's plan.

Specifically, the Administration's plan seeks to implement competitive bidding for oxygen and oxygen equipment, parenteral and enteral nutrition (PEN) and other "such other items and services" as determined by the Secretary of the Department of Health and Human Services. This provision is part of the \$238 billion in Medicare and Medicaid cuts over five years that will help pay for the Administration's proposal.

As the President of both an HME services company and the Minnesota Association of Home Medical Equipment Suppliers, I have witnessed first hand the negative effects of competitive bidding, as Minnesota's Medicaid Program currently allows for competitive bidding on wheelchairs and oxygen equipment. For that reason, I oppose competitive bidding for the HME services industry, as does NAMES. Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans. All available evidence supports this assertion.

#### **COMPETITIVE BIDDING STUDIES**

In 1986, the General Accounting Office (GAO) studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts, conducted on an experimental basis for Medicare carriers and intermediaries. After examining seven of the contracts, GAO concluded that HCFA lost money on four of them (Medicare - Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 1986). In that same report, GAO made the following observations:

- A major change in the method of contracting used in the Medicare Program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program;
- The frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance; and
- There is potential for disrupted service.

HCFA also has studied and recommended the implementation of competitive bidding for many years — without success. Between 1985 and 1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report Summary stated that:

“Competitive bidding processes per se will not necessarily result in lower Medicare costs (service and administration) for DME or clinical laboratory services in comparison to other available reimbursement methods. The ability of competitive bidding to realize savings for Medicare, while safeguarding quality, depends critically on the design, implementation and subsequent administration of the bidding system adopted. This review of the empirical literature has raised a host of issues for DME and clinical laboratory competitive bidding demonstrations, while providing considerably fewer findings that can be put forward with confidence.”

From these studies alone it is clear that competitive bidding on HME should not be an option for the Medicare program. NAMES does not oppose competition in the health care marketplace, provided that the quality of patient care and services are maintained. However, no data have been presented to indicate that inadequate competition exists today in the HME services marketplace. Indeed, the increasing number of new entrants indicates that competition is flourishing.

#### **COMPLEXITY OF IMPLEMENTING COMPETITIVE BIDDING**

Competitive bidding for certain HME items has been tried and subsequently abandoned in a number of states, no doubt due to implementation problems. Imagine the enormous complexities involved in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. Let me highlight a few examples:

- Rural communities across America will be most affected as they will not have access to hundreds of medical equipment supply items;
- Successful bidders for oxygen and other major products will not be able to provide reasonable coverage for the delivery of the full spectrum of HME items and services to all of the areas and regions throughout America; and
- Successful bidders will be delivering a significant portion of HME services. Therefore, the smaller companies that provide and service less costly and lower volume items simply will not be able to continue to provide delivery of these items, subsequently forcing them out of business. Severe delivery delays for equipment and services by large companies that may maintain their presence through the bid will occur because of the high cost of delivering HME beyond any reasonable distance, across urban areas and throughout rural areas. Thus, hospital discharges to the home will be delayed and hospital admissions will increase, while patients are waiting for the required equipment to be cared for at home.

#### **COST OF COMPETITIVE BIDDING**

Under competitive bidding structures that currently exist for oxygen in the Veterans Administration (VA), there are expectations of equipment delivery time that range from 24 hours to 72 hours from the time the order is initiated. This is necessary to allow the bidder, who now has the contract, time to service the

large geographic area as well as allow them to be as efficient as possible so they can stay in business under the lower competitive bidding rates.

- With delivery delays, there will be an increase of overall health care delivery costs. Patients will experience delays in discharge (which will severely disrupt the current DRG structure under Medicare Part A), while waiting for service.
- Under a competitive bid structure, the service levels will deteriorate significantly. Follow-up visits by health professionals that facilitate ongoing and thorough patient/physician/provider interaction, patient/caregiver education and monitoring of adherence to physician orders will be eliminated or considerably reduced.
- Emergency service (24 hours per day) will be compromised because of the distance that companies typically travel to care for patients under a competitive bidding structure. Routine maintenance checks of equipment servicing will be cut back due to cost constraints, causing concern for patient safety. All these things contribute to increased costs of providing health care.
- If only one re-admission for acute exacerbation of COPD occurs, which otherwise could have been avoided by providing the high level of in-home service that exists today, the cost of that admission for the federal government will exceed the savings achieved under competitive bidding for that individual patient for several years.

#### **THE SERVICE COMPONENT**

With any competitive bidding system, the first issue to consider must be a determination of what level of service provided by HME suppliers the government is willing to pay. Otherwise, the government should be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear. In my home state, I have heard of a number of service-related problems associated with Minnesota Medical Assistance Contracted Providers, those companies that have been awarded Medicaid contracts with the state. Some problems include:

- Inadequate patient education and training on equipment;
- Poor professional follow-up services to determine if the patient is properly using the equipment;
- Irregular equipment checks to determine if the equipment is properly working; and finally,
- Contracts allow a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and set-up.

Americans with disabilities will suffer significantly under competitive bidding because access to the custom, highly specialized equipment that they require will diminish. We estimate that the small percentage

of HME suppliers who could remain in business under this type of structure would not be able to provide this type of high cost, low margin and highly serviced equipment to all corners of the country.

My company services approximately 100 oxygen patients with 90 of them being Medicare beneficiaries. Typically, we provide an average of three after hours (evenings and weekends) calls per week to provide emergency service to patients or new set-ups. If these patients were not adequately serviced on a timely basis, then costly hospitalization would result. Often, new orders for oxygen in the home are initiated from an urgent care clinic or hospital emergency room, thereby avoiding hospital admission.

Under competitive bidding, a rapid response time by a limited pool of providers will not be possible; this could result in an additional hospital admission, which will be extremely costly. Imagine extending the above numbers across the country under the Medicare program.

#### **IMPACT ON SMALL HME SUPPLIERS**

Implementing competitive bidding would radically restructure the way HME services are provided. Further, it will be very hard to design and administer any competitive bidding process without damaging the market. If a winning bid is awarded solely to one provider within a given "service area," as currently proposed by the Administration, this certainly will drive many small companies out of business. The sole winner in future years thus would have a considerably reduced level of competition — and considerably reduced choices for consumers in choosing an HME provider.

Under competitive bidding, winning companies could resort to using "predatory pricing" techniques, knowing they will have a monopoly on the market and eventually will be able to drive costs back up as competition will no longer exist. The outcome again is poor service and quality, limited access and short- and long-term increased costs of health care.

Another HCFA-initiated Abt report substantiated the claim that competitive bidding might force some suppliers who participate in the Medicare system out of business:

"...complete loss of that business would place most suppliers in an extremely tenuous financial situation. For this reason, a bidding system that totally disallowed Medicare reimbursement for customers who choose to use losing suppliers would definitely reduce some suppliers' business and eventually force them out of the market."

## **OTHER COMPETITIVE BIDDING MODELS**

Competitive bidding is known to work poorly both for the Defense Department and the VA, where this technique already is used on a large scale, similar to what Medicare would require. VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA competitive bidding contract winners.

Under the Administration's plan, we would have to expect similar, if not greater, problems in access and quality. The VA, once acquiring a signed contract in certain states, has monitored the provider for provisions of services only to find they have no awareness of home oxygen and HME items in the areas of: quality; appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment.

British Columbia, Canada, has had a competitive bid process for HME services in place since November 1991. There, the government uses a scheme of establishing a "preferred" provider based on lowest bid and up to 2 "approved" providers based on next lowest bid in each health unit (7 units in British Columbia). Typically, this system allows for:

- 48 hours to set up new patients, from time of initial order;
- A three year bid period with the government option to renew every year if the provider is not performing based on confirmed complaints;
- Concentrators, liquid oxygen systems, portable systems and contents to be bid and paid for separately. Contents are based on actual usage;
- Government mandates on patient follow-ups/assessments done every 6 months as a minimum, but can be done more often if so desired;
- Government mandates that require concentrators to be maintained at a minimum of every three months and more often if desired;
- The preferred and approved vendors compete on service and are permitted to obtain clients based on referral, physician or patient preference, even though providers will be paid at different rates based on their bid; and
- An overall decline in service levels because patients have remained in hospitals longer. Service delays and hospital admissions have more than likely increased because of minimal patient/provider/physician interaction.

Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact we predict that such a system would have on patients, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment services.

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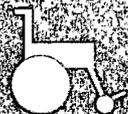
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**INFORMATION,  
RESEARCH AND  
STATISTICS  
ON HOME CARE  
AND THE  
HOME MEDICAL  
EQUIPMENT  
SERVICES  
INDUSTRY**

# **Health Care at Home:**

**A HOME CARE DIGEST**

**National Association of  
Medical Equipment  
Suppliers (NAMES)**

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