The Home Care Network
Jefferson Health System

February 12, 2009

Extended Home Care

Home Health

Home Infusion Service

Hospice and Palliative Care

Rehab Equipment Services

Respiratory and Home Medical Equipment

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1561-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Interim Final Rule - DME Competitive Bidding

Dear Administrator Weems:

Attached please find comments concerning the recent release of the Interim Final Rule related to changes to the Competitive Acquisition of certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), submitted on behalf of our DME provider unit.

We are disappointed that this revised rule failed to register any change to two wide criticisms from Round 1 - awardees without operations in the MSA where they received an award and a need to provide the industry with a framework for entering into sub-contracts. We also note that sub-contracts need to be signed and included with any bid - but implementation contingent on a primary award being granted.

Overall, while we have never been convinced that this arrangement will work to lower costs in the long term and also be able to maintain customer access to quality care, absent a change by Congress, we believe our suggested changes are required at a minimum before the plan moves forward.

Very truly yours,

Theodore A. Bean
Head - Financial Analysis

CENTER for MEDICARE and MEDICAID SERVICES (CMS)

COMMENTS REGARDING INTERIM FINAL RULE
Covering the DMEPOS Competitive Acquisition Program

JeffQuip, Inc has been an authorized provider of DMEPOS items under Part B of the Medicare Program since 1990. As such, we have had to respond to the periodic lowering of reimbursement CMS has made to durable medical equipment rates already several times. Some of these changes may have been appropriate, but we continue to believe that most of the concerns impacting the growth of the DMEPOS payments have been the result of lax oversight and enforcement of provider billing, lax enforcement of processes granting new providers authority to bill, and lax enforcement of on-site reviews of newly applying candidates to confirm that they were, in fact, operating legitimate businesses. The recently released O.I.G. report on DME claims being paid where the physician UPIN was either false or terminated, noting fraud of about $34 million is further proof that the contracted intermediaries working in conjunction with CMS are the real perpetrators of DME over-payments.

That said, we believe the Competitive Acquisition Program for DMEPOS providers was a legitimate Congressional response to the inadequacy of CMS and its hired contractors to ferret out fraud and contain Medicare Trust Fund spending. Unfortunately, we see the initial ten MSA (now nine) effort as a massive failure on the part of CMS to demonstrate they have any understanding of the existing DMEPOS provider industry. Competitive bidding, coupled with the added burdens (costs) of accreditation and surety bonds will transform this industry from one rightly characterized as vibrant, growing and with significant competition to an industry with a few giants, unresponsive to just about everything, except getting paid for claims submitted to their regional intermediaries.

During the first version of Round 1 of the Program, based on the results, only approximately 5% of providers who submitted bids were awarded bids. It is curious that for just one of the MSAs selected, Pittsburgh, that the total number of awardees for all ten MSAs was slightly less then the total number of authorized DMEPOS suppliers then currently active CMS authorized DME providers in the Pittsburgh MSA.

While CMS has noted in this Interim Final Rule that 329 entities were awarded bids in the original first round, many of those awardees were national or large regional operators, with many such firms awarded bids in nearly all of the ten MSA regions in Round 1.

We have had discussions with industry participants wherein they have advised that they had been approached by the successful awardees to enter into a sub-contract to supply the actual products in the areas where said awardee had obtained the contract. In some instances, we are aware that certain contract bid awardees had no base of operation within the cited geographic MSA. In one instance we were advised that the awardee had approached a local supplier in a region where they had no physical presence, and offered to have that local supplier become a sub-contractor at either 45% or 50% of the bid award price. In other words, the awardee anticipated they could keep half or more of allowable reimbursement for every item supplied without performing any services but billing and collection.

A major concern of industry representatives to the Round 1 program was that access to care would be lessened, and the quality of services provided would deteriorate. A study by Carnegie-Mellon economists, widely circulated within the industry cited the "franchise Fee" economic theory, which noted that once bids were secured, that numerous small providers will leave the industry, yielding at least an oligopoly of power in each bid area, if not defacto monopoly power to the award winners.

Many existing CMS-authorized DME suppliers are small businesses. The recent CMS Surety Bond final rule shows the following:

Allowed Charges by Approved Provider	Total Number of DMEPOS Suppliers in this Revenue Range	Percentage of Total Number of Suppliers
$0	6,671	10.10%
$0.01-$999	9,168	13.90%
$1,000-$2,499	7,092	10.70%
$2,500-$4,999	6,744	10.20%
$5,000-$9,999	7,117	10.80%
$10,000-$24,999	8,896	13.50%
Small Suppliers Likely to Exit the Market Just Due to Accreditation & Surety Bond Costs	45,688	69.20%
$25,000-$49,999	5,478	8.30%
$50,000-$99,999	4,026	6.10%
$100,000-499,999	7,146	10.80%
$500,000-$999,999	1,982	3.00%
$1,000,000-4,999,999	1,450	2.30%
$5,000,000 or more	215	0.30%
Total	65,984	100.00%

We have inserted the break for all suppliers with revenue less then $25,000, added a sub-total to the table, and noted that there is a high probability that over forty-five currently authorized providers will be forced out of this business as they cannot absorb two additional cost items already promulgated by CMS - accreditation and surety bonds (accreditation expected to cost about $3,000 every three years and surety bonds expected to cost $1,500 annually, for a total of $2,500 annually) which costs probably exceed normal profit for all operators with less then $25,000 of revenue.

As the results of Round 1 showed, many additional providers were going to be eliminated as competitors. We certainly do not think that was the intent of Congress when it established the Competitive Bidding Program. In the current economic climate, moving forward with the Competitive Acquisition Program largely unchanged is nearly criminal. The government will be putting people out of work.

Two related pitfalls with the first program need to be changed. They are:

> Any and all sub-contractors must have an agreement signed, contingent on the primary bidders winning an awarded contract, that they will provide some of the needs of the awardee, and that they have committed to the primary bidder their intention to fulfill such a contract term if the primary bidder wins the award. This change would ensure that winners cannot capitalize on their "Franchise Fee" award after the fact. While the accreditation requirement should eliminate awardees without operations in the cited MSAs, CMS needs to strengthen their review process of this bidder requirement. It might even be appropriate for CMS to perform on-site reviews of intended awardee and sub-contractor operations to confirm capability to supplying the full geographic area encompassing each MSA - a requirement bidders must say they meet.
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> We also suggest that it would be very beneficial for CMS to provide a Sub-Contract Template. This will allow CMS to confirm in advance that all sub-contractors are also adhering to the Program standards, with sub-contractors being accredited and having surety bonds.

Providing a Sub-Contract Template will assist the many remaining 20,000 who we estimate could remain in business after the implementation of the accreditation and surety bond rules in having a foundation on which to pursue a bid. Issues raised in Round 1 regarding anti-trust and competitive bid collusion could be avoided if a well crafted contract template was developed. If CMs deems this effort outside its scope of responsibility, we suggest it delay this re-bid round until some industry groups can develop this document. If not produced by CMS, we would suggest that Congressional action be pursued to further delay this rule being implemented. The economy does not need 20,000 small business being forced to close.

Lastly, as we noted in our introduction, we suggest that Congress had seen and heard about too much fraud in the DME arena, which became the triggering issue compelling some action to constrain spending. While we believe the Program as structured confirms the observations of the Carnegie-Mellon team, namely that the Program would result in numerous "Franchise Fee" buy-in awardees, we were even further surprised that one of the awardees in many of the original ten MSAs had recently entered into a major settlement with CMS and made a considerable penalty re-payment for improperly billing the Medicare Trust Fund. We cannot think of a single logical reason why that firm was given such a wide array of awards. Perhaps, had they received an award in one MSA, and demonstrated they were properly complying with CMS DME-supplier billing rules and requirements, they could have been considered eligible for the second round of bidding.

We thank you for your time in reviewing our comments, and urge you to make the changes suggested. If delay is needed, CMS also needs to make that announcement as soon as possible.