

Congress of the United States  
Washington, DC 20515

September 29, 2003

The Honorable Bill Thomas  
Chairman  
Committee on Ways and Means  
1102 Longworth House Office Building  
Washington, D.C. 20511

Dear Chairman Thomas:

We are writing to express our concerns about the House provision, in HR 1 that would establish a national competitive bidding system for durable medical equipment (DME).

It is our understanding that the legislative support for competitive bidding for DME is based in large part on the previous work done by the General Accounting Office (GAO). As you know, the GAO concluded that because the Department of Veterans Affairs (DVA) was able to purchase many items of DME at rates far cheaper than Medicare, DME suppliers were being overpaid by Medicare. The trouble with the GAO's analysis is that the cost of purchasing a DME item by the Department of Veterans' Affairs is not reflective of the item's total acquisition cost.

For instance, when the VA purchases a wheelchair directly from its manufacturer, the wheelchair usually comes to the VA in a box, and it needs to be assembled and fitted for the patient who will be using it. Many items of DME also need to be explained, sometimes in great detail, to the patient or else the patient can become injured or sick because they do not use, maintain, or clean the item properly. The substantial costs of assembly, fitting, delivery to the patient's home, and patient usage instruction are usually not included in the GAO's analysis. Moreover, if the VA does not have in-house staff available to do these tasks, the VA will contract out this portion of the job to a local DME supplier, GAO apparently did not include the VA staffing costs, nor did it include the contracting out costs of delivery and instruction. We believe that if the GAO had included such costs, the perceived gap in the costs between the VA and Medicare would narrow considerably.

Another concern for us is that because GAO's analysis has flaws, the policy implications drawn from this analysis - i.e. competitive bidding for DME - may not be warranted. There is little doubt that if a contractor wins a low-bid contract from Medicare to provide all DME items for an entire region, the low-bid contractor will have little or no incentive to conduct patient education on the proper use, maintenance, and cleaning of the items furnished to them. Every minute of patient instruction will be viewed by the low-bidder as a money-losing operation that must be minimized at all costs in order to make sure the overall Medicare contract can be completed within its allotted funding.

And what will be the consequences for Medicare? It will mean a major reduction in

quality of service. It means that a patient in a wheelchair who gets his or her wheelchair dropped off at their house without any customization or instruction will be at higher risk of pressure sores. It means a urology patient who gets urologic supplies without proper instruction how to clean and change the items, could develop a urinary tract infection (UTI) that requires hospitalization. It would mean that Medicare could end up spending more money to hospitalize patients who otherwise would have never been injured or harmed had they received the necessary patient education on the DME items prescribed for them by their physician. But will the low-bidder care? Of course not. Hospitalization expenses come out of another part of the federal budget. The only budget that matters to the low-bidder is making sure his delivery men make their rounds on time, and if that means dropping off their packages at the door when no one is home, or cutting short a conversation with a patient to make their next delivery then so be it.

We are well aware that Medicare has conducted a handful of demonstration projects on competitive bidding. But most of the Department of Health and Human Services (HHS) analyses of how these demonstration projects have fared are either incomplete or inconclusive. On the other hand, a Pricewaterhouse Coopers (PwC) analysis of last year's competitive bidding proposal found that the Congressional Budget Office's (CBO) estimate of savings was wildly inflated by a factor of at least seven. Specifically, PwC found that the administrative costs of the competitive bidding program were not included in CBO's estimate. CBO simply assumed that the administrative costs would be absorbed by HHS and that something else would get cut to make room for the expansion of managerial capability needed for competitive bidding. This is a major issue, because a national competitive bidding system would take a serious and sustained managerial effort to execute successfully, and the administrative costs of the program would be considerable. It is unrealistic in the extreme to assume, as CBO does, that the program could be executed within the Centers for Medicare and Medicaid Services' (CMS) present budget. The track record of CMS is not exactly stellar in this regard.

In conclusion, after examining the evidence and studying the literature on competitive bidding, we recommend that the final Medicare bill adopt the Senate provisions on DME, which would eliminate overpayments to DME suppliers by freezing payment updates for a set period of time. Thank you for your consideration of our views on this matter,

Sincerely,

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CHRISTOPHER H. SMITH  
Member of Congress

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JIM SEXTON  
Member of Congress