Statement of the
National Community Pharmacists Association

“Medicare’s Competitive Bidding Program for Durable Medical Equipment: Implications for Quality, Cost and Access”

United States House of Representatives
Subcommittee on Health
September 15, 2010
Chairman Pallone, Ranking Member Shimkus, and Members of the Committee, the National Community Pharmacists Association (NCPA) is pleased to submit the following written comments for inclusion in the record of today’s hearing, Medicare’s Competitive Bidding Program for Durable Medical Equipment: Implications for Quality, Cost, and Access. We commend you for holding this hearing given the impact that competitive bidding may have on beneficiary access to needed diabetic testing supplies and other DME supplies as well as the ability of community pharmacies to serve the DME supply needs of Medicare Part B beneficiaries, particularly Medicare B beneficiaries’ needs for diabetic testing supplies.

NCPA represents the interests of pharmacist owners, managers, and employees of more than 22,700 independent community pharmacies across the United States. NCPA has a strong interest in this issue because independent community pharmacies hold one-half of all active DME supplier numbers and serve as a critical access point for DME supplies, especially diabetic testing supplies, for the large fragile population of Medicare Part B beneficiaries suffering from diabetes in the United States.

Congress Should Pass Legislation Permanently Exempting Small Independent Pharmacies from a Diabetic Testing Supply CBP

Recently, CMS promulgated a Proposed Rule to continue, for the time being, to exclude diabetic testing supplies (DTS) supplied by retail pharmacies from the competitive bidding program (CBP). While we support CMS’s efforts, we urge Congress to pass H.R. 5235 (sponsored by Congressmen Welch and Rogers), The Medicare Access to Diabetes Supplies Act, which would permanently exclude retail pharmacies from DTS CBP’s. Without such Congressional action, applying a DTS CBP to community pharmacies would, as CMS has stated, “likely eliminate beneficiary choice to obtain replacement diabetic supplies on a non-mail order basis from any enrolled supplier that is a pharmacy or other local supplier storefront.” If small independent pharmacies were to be included within a DTS CBP, such a program would prove unduly burdensome to independent pharmacies and could cause many of them to leave the program and stop supplying DTS supplies.

In the aborted first round of CMS’s CBP for DTS, less than two percent of the suppliers submitting bids were independent pharmacists, despite the fact that community pharmacies hold one-third of all, and one-half of the active, DME supplier numbers. This demonstrates that under a CBP many small independent pharmacists will likely terminate sales of DTS, and they will do so because independent community pharmacies do not have the volume of diabetic testing supply business to be able to submit successful competitive bids.
Moreover, the result of small independent pharmacists potentially terminating their sales of DTS is that patients will be forced to use mail order, will lose access to care, and the patients and the health care system will incur unnecessary costs in the long term. The resulting narrowing of patient access is demonstrated by predictions that 38 to 40 percent of DME suppliers are expected to go out of business under the CBP and 80,000 people will lose their jobs. Through mail order, patients will also lose access to care because they will lose access to the valuable consultation, fitting and monitoring services provided by independent pharmacists. Various studies have documented the benefits of personal care, particularly in diabetes care, and some have extrapolated the negative effect on patient care of placing DTS in competitive bidding. Even CMS, in the preamble to its recent Proposed Rule on CBP, noted the value of “a licensed pharmacist [being] on hand to offer guidance and consultation to the beneficiary.”

Viewing a CBP for DTS over the long term, even if the per unit cost of DTS is lower under a CBP than a non-CBP environment, the cost savings are illusory as the per unit costs do not account for long term waste and additional medical spending that inevitably follow a CBP. Converse to the hidden long term costs of a CBP, there are hidden long term savings inherent in the value of the face-to-face relationship between a patient and his or her independent pharmacist. Because of that face-to-face relationship, our patients are more likely to: take their medicines on-time; take them properly; refill meds before they run out; and avoid harmful drug interactions. This patient behavior, in turn, helps to lower health care costs by promoting patient health every day. Accordingly, the alternative, forcing patients to turn to mail-order suppliers, will lead to reduced quality of health care and health outcomes, and higher health care costs.

In light of the negative impact of a CBP for DTS on the ability of community pharmacies to continue to supply DTS and in narrowing patient access to DTS, NCPA urges Congress to pass H.R. 5235 and permanently exclude small independent pharmacies from the CBP. H.R. 5235 would exclude from a CBP “blood glucose self-testing equipment and supplies furnished by a retail community pharmacy (as defined in section 1927(k)(10)) that is a small business concern (as defined in section 3(a) of the Small Business Act (15 U.S.C. 632(a))).” Congress should pass H.R. 5235 because it will protect patients’ important face-to-face interaction with their independent pharmacists for effective diabetes monitoring and ensure that beneficiaries will have immediate access to the specific DTS that they need.

Along with excluding community pharmacies from any DTS CBP, NCPA also urges Congress to pass legislation to exempt community pharmacies from any pricing resulting from a DTS CBP. Such an exemption is necessary to protect meaningful beneficiary access to small independent pharmacies. Even if small independent pharmacies are excluded from a CBP, they may still terminate DTS sales and hinder beneficiary access to DTS if the prices established under such a program are applied to the community pharmacy market. This would make it cost prohibitive for our members to continue supplying DTS products. In the end, if Congress does not protect
beneficiary access to small independent pharmacies, beneficiary compliance with testing regimens may be compromised, and the risk of diabetes-related complications may rise along with costs associated therewith.

**Congress Should Allow Community Pharmacies to Continue to Provide Home Delivery of DTS Supplies Outside of the DTS CBP**

Presently, CMS applies a CBP to mail order DTS in specified competitive bidding areas and is contemplating a national mail order DTS CBP. In doing so, CMS has proposed to define the term “mail order” to mean “any item . . . shipped or delivered to the beneficiary’s home, regardless of the method of delivery.” Conversely, CMS has proposed to define the term “non-mail order” as “any item . . . that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.” Essentially, the proposed revised definitions prevent small independent pharmacies, which are not a part of the CBP, from providing home delivery, which is a valuable and necessary service for some beneficiaries who have difficulty getting to a pharmacy. For example, in 2009, 76% of small independent pharmacies offered home delivery services. Moreover, anecdotal evidence suggests that 40-50% of Medicare beneficiaries do not pick up their pharmaceutical drugs or supplies themselves, meaning they are either delivered to the beneficiary by the independent community pharmacy or picked up at the pharmacy by a caregiver.

Two scenarios further demonstrate the problems with prohibiting community pharmacies from engaging in some home delivery of DTS. First, many Medicare Part B beneficiaries that are in need of DTS are homebound and may not have a caregiver available to pick up DTS from the local independent pharmacy. In these instances, the beneficiary relies upon the independent pharmacy to deliver supplies to their home. This is done for the benefit and convenience of the beneficiary, and not to undermine the CBP.

The second scenario occurs when a small independent pharmacist temporarily delivers supplies to a patient. This scenario involves the “snowbird” patients, who live in the North during the summer and head south to places like Florida in the winter. Their pharmacist in the North, for the convenience and benefit of the patient, may be willing to mail winter supplies to the patient at their southern address. This is a temporary arrangement and is not done to undercut the CBP, yet the proposed definitions would prohibit small independent pharmacists from performing this helpful service. Notably, under either of the above scenarios the independent pharmacist obtains a receipt that the item was received by the beneficiary, the same documentation that the pharmacist receives from an in-store pick-up.

In light of the concerns raised by CMS’s proposed definition of the terms “mail order item” and “non-mail order item,” NCPA urges Congress, in enacting legislation exempting community pharmacies for a DTS CBP, to ensure that community pharmacies are able to continue to deliver DTS supplies to homebound beneficiaries and “snowbird” patients. To do so would be consistent with the Medicare Part D program, which does not consider a small independent pharmacy providing home delivery of a Part D drug to be providing a mail order service.

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Congress Should Enact Legislation Exempting All Small Independent Pharmacy Supplied DME from any CBP’s

Along with excluding small independent pharmacy supplied DTS from the CBP, NCPA also urges Congress to exclude small independent pharmacies from all future rounds of the CBP for all community pharmacy supplied DME products. Small independent pharmacies not only provide DTS, but also serve as a source for beneficiaries who need walkers, crutches, canes and commodes, among other supplies.

Like DTS, the sale of these DME supplies is a volume driven business. Accordingly, those suppliers with more volume, such as mail order companies and larger chain pharmacies, can afford to bid lower prices in a CBP and still profitably sell the supplies. Conversely, small independent pharmacies do not deal with such large volumes, do not have the economies of scale to match the low bids inherent in a CBP and cannot profitably sell DME supply items in the context of a CBP. As stated previously, this results in small independent pharmacies dropping out of the CBP and ceasing to supply DME supply items. The end result is that patients’ access to DME supplies is narrowed, as patients are forced to turn to mail order for their supplies.

In order to promote patient access to DME supplies, patient utilization of DME supplies and to maximize positive patient health care outcomes from the use of DME supplies, Congress should enact legislation exempting all small independent pharmacy supplied DME supplies from future rounds of the CBP.

Conclusion

If community pharmacists are not exempted from the CBP for Part B DME supplies and DTS, in particular, then many will likely cease to provide such supplies, thereby narrowing beneficiary access to much-needed DTS, and other products, such as canes and walkers. NCPA has urged CMS to continue to exempt community pharmacies from DTS and DME CBP’s, as well as requesting that community pharmacies be exempt from the DTS CBP pricing and be allowed to continue to provide home delivery of DTS outside of the CBP. NCPA stands ready to work with CMS on the CBP for DTS and other DME. However, if CMS does not take action to permanently exempt community pharmacies from the DME CBP, then Congress must act to ensure that Medicare Part B beneficiaries continue to have access to the high quality DTS and other DME supplies at their local community pharmacies.

Thank you for the opportunity to submit this statement for the record. If you have any questions, please contact John Coster, Ph.D., R.Ph., Senior Vice President, Government Affairs at (703) 683-8200.