DME Suppliers May Face Big Changes in 2008

BY ALICIA AULT
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Starting in April 2008, retailers and suppliers in 10 metropolitan areas who sell certain durable medical equipment will have to become accredited and enter a competitive bidding process, according to a final rule issued by the Centers for Medicare and Medicaid Services.

Unlike other entities, physicians may opt out of competitive bidding and accreditation, but they will still have to accept a single payment for the durable medical equipment (DME) item instead of a fee schedule–based payment, Acting CMS Administrator Leslie Norwalk said in a briefing with reporters.

The new competitive bidding program was developed to reduce Medicare's substantial DME expenditures and to decrease the out-of-pocket burden for beneficiaries, who are liable for copayments of 20%.

"The final rule we are announcing today is focused on improving both service delivery and the quality of care, while getting savings for beneficiaries and taxpayers," Ms. Norwalk said in a statement.

She estimated that Medicare could shave $1 billion a year off its DME tab by the time the program is fully implemented in 2010.

The final rule will apply initially only to 10 categories of supplies and only to suppliers in 10 competitive bidding areas (CBA) that have been established by CMS. Physicians, hospitals, and other entities that sell DME, prosthetics, orthotics, and certain other supplies will be required to submit bids to CMS proposing charges for the items.

Bidding will probably be open from late April until late June. CMS will evaluate the bids and then, probably in December, the agency will award contracts to a certain number of bidders in each CBA, Ms. Norwalk said in the briefing. Beginning in April 2008, Medicare will pay a single amount for each item in those areas instead of basing payments on a fee schedule, as it has in the past.

CMS will expand the program to 70 bidding areas in 2009, and to more CBAs, and to coverage for more DME items after that, Ms. Norwalk said.

The new process was required by the Medicare Prescription Drug Improvement and Modernization Act of 2003. CMS outlined its intentions in a proposed rule in August 2006. It also gathered data from two pilot studies that ran from 1999 to 2002 in San Antonio and in Polk County, Fla., Ms. Norwalk said. After incorporating public comments and experience from the pilot, CMS published the final rule in the Federal Register.

Suppliers in the following 10 areas will be the first subject to the new requirements: Charlotte-Gastonia-Concord, N.C./S.C.; Cincinnati-Middletown, Ohio/Ky./Ind.; Cleveland-Elyria-Mentor, Ohio; Dallas–Fort Worth–Arlington, Tex.; Kansas City, Mo./Kans.; Miami–Fort Lauderdale–Miami Beach, Fla.; Orlando-Kissimmee, Fla.; Pittsburgh; Riverside–San Bernardino–Ontario, Calif.; and San Juan–Caguas-Guaynabo, Puerto Rico.

The locations were selected because they are 10 of the largest metropolitan statistical areas in the United States and because each area had high costs and/or high utilization of DME items in the 10 focus categories. Although New York, Los Angeles, and Chicago are among the largest metropolitan statistical areas and have high costs and utilization, CMS decided to exclude those areas initially to simplify the process, Ms. Norwalk said.

The 10 categories include oxygen supplies and equipment; standard power wheelchairs, scooters, and accessories; complex rehabilitative power wheelchairs and accessories; mail-order diabetes supplies; enteral nutrients, equipment, and supplies; continuous positive airway pressure (CPAP) devices; respiratory assist devices, supplies, and accessories; hospital beds and accessories; negative pressure wound therapy pumps, supplies, and accessories; walkers and related accessories; and support surfaces (group 2 and 3 mattresses and overlays). In most CBAs, only nine categories will be subject to bidding in 2008. All 10 will be covered in the Miami and the San Juan areas.

Since 60% of diabetic supplies are delivered through mail order, CMS decided to require those suppliers to be subject to competitive bidding. Thus, patients with diabetes will continue to have the option of mail order and it should be less costly, according to CMS. Payment for supplies obtained at a pharmacy or elsewhere will still be covered under the old Medicare fee schedule, even in the 10 CBAs, the agency said.

Blood glucose monitors are not subject to competitive bidding.

To qualify to bid, suppliers have to be accredited by 1 of 10 agencies certified by CMS. Those include the Joint Commission on Accreditation of Healthcare Organizations, the Board of Orthotist/Prosthetist Certification, and the Accreditation Commission for Health Care Inc.

Generally, bidders also have to be in good standing with Medicare, have an active National Supplier Clearinghouse number, and agree to service an entire bidding area, regardless of where a beneficiary may be located. Of the winning contract slots, 30% are set aside for small suppliers—those with gross revenue of $3.5 million or less per year. ■

A list of all of the accrediting bodies, the bidding criteria, and other key details can be found online at www.cms.hhs.gov/CompetitiveAcqforDMEPOS.

Physicians Reservedly Applaud New Unfunded Trauma Law

BY MARY ELLEN SCHNEIDER
New York Bureau

Newly enacted federal legislation is a first step toward new funding to improve preparedness and care in the nation's trauma centers, experts in emergency medicine said.

In May, President Bush signed into law the Trauma Care Systems Planning and Development Act of 2007, reauthorizing the program through 2012 and authorizing $12 million in funding for fiscal year 2008, $10 million for fiscal year 2009, and $8 million annually for fiscal years 2010-2012.

The law resurrects the Department of Health and Human Services' Trauma-EMS Program, which was originally established by Congress in 1990 and has provided more than $31 million to states and territories to help develop and implement statewide trauma systems. However, over the years the program has struggled to receive adequate funding, and in fiscal years 2006 and 2007 it received no funding.

The law also authorizes funding for existing emergency medicine residency training programs at $400,000 annually from fiscal years 2008-2012.

The law is supported by the American College of Emergency Physicians and the American College of Surgeons, as well as other groups.

"We view this as a critically important piece of legislation but only a first step," said Dr. Mary Pat McKay, director of the center for injury prevention and control at George Washington University, Washington. Dr. McKay also serves as chair of ACEP's trauma and injury control committee.

The next step is for Congress to appropriate the full amount, and for officials at HHS to quickly get the money down to the state level. There are likely to be some delays at the local level because in the 2 years that the program has been zero funded, local staff has left or been shifted to other duties, she said.

"The federal government has finally realized there's a crisis going on," Dr. McKay said. "People aren't getting to optimal care in every case." In fact, only about one-fourth of the population in the United States lives in an area served by a trauma care system, according to the American College of Surgeons. And a recent series of reports from the Institute of Medicine found that the emergency care system is ill equipped to handle a major disaster.

The IOM found that with many emergency departments at or over their capacity, there is little surge capacity in the event of a natural or manmade disaster. Emergency medical technicians in non–fire-based services also lack needed training, receiving an average of less than 1 hour of training in disaster response. And both EMS and hospital personnel do not have the personal protective equipment that would be necessary to respond to a chemical, biological, or nuclear attack.

In addition to reauthorizing the Trauma-EMS Program, the law also creates a separate competitive grant program aimed at helping those states that are further along in developing statewide trauma care systems and who meet national standards and protocols.

The new law also provides for grants for research and demonstration projects in rural areas centering around innovative uses of communications technologies, the development of model training curricula, and the management of EMS systems.

Enactment of this law will have an effect not only in terms of the money available through grants, but also in terms of national leadership from officials in HHS's Health Resources and Services Administration (HRSA), which administers the program, said Dr. Robert R. Bass, director of the Maryland Institute for EMS Systems, Baltimore, and a member of the ACEP EMS and tactical emergency medicine section.

Through the program, HRSA has developed a model trauma plan, which has been very useful for states, Dr. Bass said. And since the program was first authorized in 1990, the number of states with statewide trauma systems has been increasing and existing programs have been improving, he said.

The passage of the Trauma Care Systems Planning and Development Act is an important first step, Dr. McKay said, because it allows for pilot projects at the state level to test new ideas and strategies, and will aid in the purchase of new equipment.

But in the long run, much more work is needed to get all states and territories to the same level of trauma system development. Right now, development is variable; some states have advanced information systems in place, whereas others still use paper and pencil systems, she said.

Variations in the way EMS operates in this country remain an unmet challenge, Dr. McKay said. In some places, EMS is a third municipal service, or it could be run by a private company, or it may be part of the local fire department. ■

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