DME Suppliers Face Big Changes Next Year

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 (CBAs) 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, 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 cover 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.

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Wheelchairs are among the DME items that will be subject to a new competitive bidding process being phased in by Medicare.

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 and supplies and accessories; hospital beds and accessories; negative pressure wound therapy pumps and 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 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. ■

For a list of accrediting bodies, bidding criteria, and other details, see www.cms.hhs.gov/CompetitiveAcqforDMEPOS.

Monitoring the Financial Health of Your Practice Is Critical

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — Preparing a budget and regularly compiling financial reports is critical for any physician practice to maintain a healthy bottom line, financial experts said at the annual meeting of the American College of Physicians.

"It's important to keep your eye on your cash flow," said Margo J. Williams of the ACP Practice Management Center in Washington.

Several standard financial monitoring tools—balance sheets, income statements, budgets, and accounts receivable reports—can help give physicians an overall picture of how the practice is doing and provide early warning of potential problems.

The balance sheet is often misunderstood, said Carl B. Cunningham, director of the ACP Practice Management Center. For the average physician practice, the balance sheet is mainly useful when trying to sell the practice because it lists the accumulated assets and liabilities. However, because the balance sheet is really just a snapshot of one point in time, it's not very useful in managing the practice day to day, he said.

A better tool for daily management of the practice is the income statement, Mr. Cunningham said. This allows physicians to measure, over a specific period, their revenues and expenses. He recommends analyzing the income statement monthly.

But the income statement also has a drawback: It describes the financial state of the practice, but it doesn't help determine how the practice should be performing. That's where having a budget comes in, Mr. Cunningham said.

"An awful lot of practices never bother to prepare a budget," he said. "I would strongly encourage you to do so because what it does is provide a planned income statement."

By preparing a budget, physicians can sit down in advance and figure out where they want to be financially and what types of expenses and revenue will be needed to get there. This type of budgeting exercise can be done for the whole practice, as well as when evaluating new ancillary services. And because the budget is there to serve as the guideline, it can also help physicians delegate some financial tasks to other staff, Mr. Cunningham said.

For those physicians who are ACP members, the staff at the Practice Management Center can provide a one-page summary of the practice's key financial data. The one-page report includes charges, patient visits, and accounts receivable by month and year-to-date. This tool can be an easy way for a busy physician to quickly evaluate his or her practice, Mr. Cunningham said.

"Accounts receivable management is another area that is critical to monitoring the financial status of your practice," Ms. Williams said.

Accounts receivable, which is the money that is due but has not yet been received, is an area where everyone from the front desk receptionist to the physician can play a role, she said. The goal should be to get things right the first time in terms of getting out clean claims, staying on top of denials, and finding out why claims are being denied.

Continuous monitoring of accounts receivable also is important. Some of the tools that physicians and their staff can use to oversee this area include tracking the days in accounts receivable, to find out how long it takes to collect, and calculating gross and net collection ratios, which show how much is being collected.

The average number of days that charges spend in accounts receivable can be calculated in two steps. First, take the total charges and divide by 365 days to get the average daily charges. Then, take the total accounts receivable balance and divide by the average daily charges. For most practices, the average number of days in accounts receivable is about 37, Ms. Williams said.

Collection ratios can be helpful in determining the share of the accounts receivable that has actually been collected. But when calculating collection ratios, keep in mind that the gross collection ratio is easy to figure out but is influenced by the fee discount contracted with payers, and so it is not a pure measure of collections performance.

The net collection ratio is a better indicator of performance because it is based on contracted fees that can actually be collected. However, this number is difficult to calculate without a sophisticated practice management system that builds accurate payer fee schedules into the computer, Ms. Williams said. ■

Information on the ACP Practice Management Center is available online at www.acponline.org/pmc.