

PROVIDERS NEED SOLUTIONS TO DEAL WITH COMPETITIVE BIDDING *by Vernon Pertelle RRT MBA*



In compliance with the Medicare Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) will open a competitive bid program for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). The new program, which is required by the MMA of 2003, would replace the current DMEPOS fee schedule payment amounts for selected items in select areas. The program will be phased in during 2007 and will initially include the 10 largest of 80 metropolitan statistical areas (MSAs), with the current exceptions of New York City, Los Angeles, Chicago, rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service (e.g. diabetic supplies, respiratory medications). CMS has discretion under the law to first phase in DMEPOS items for bidding based on high cost and volume or largest savings potential. As such O2 will definitely make the cut as one of the initial items that is included in the bid process. Once the program is fully implemented the overall reimbursement to HME providers who service the oxygen needs of Medicare beneficiaries would be reduced and according to CMS the savings from the overall program will exceed \$1 billion annually.

In addition to the competitive bidding program CMS plans to impose a 36-month cap on rental for oxygen concentrators in which ownership would be transferred to the Medicare beneficiary. Although there are efforts to prevent the cap process from occurring, the likelihood is that it will go forward, thus HME

providers must develop a plan to reduce the negative impact on their bottom line. CMS is also engaged in an effort to encourage all beneficiaries to sign over their benefits to managed care organizations (MCOs) so HME providers must also refocus their marketing to include MCOs. In order to deal with these many changes HME providers must proactively develop the infrastructure that eliminates waste with their operations, invest in information technology that adds efficiency with intake, billing and allows providers to track satisfaction and outcomes in preparation for 'pay for performance' [or P4P] and quality standards and realign their equipment purchases to incorporate oxygen systems that helps to reduce expense and labor while not compromising patient quality as the program also requires all HME providers be accredited by an approved accreditation organization to ensure they meet applicable quality standards. Ultimately the HME provider is faced with the tough decision to get acquired and continue to operate the business, sell their business or open up a yogurt shop and get out altogether.

Stop the press! Now you will ask the question: What are the solutions and how do I deal with the impact of competitive bidding? Well as stated previously the yogurt shop is not such a bad idea. On the other hand most of you probably don't like yogurt and you want more substance to help you truly understand how you can succeed and stay in the HME business. Some of you are located in areas that will not be impacted by competitive bidding however can't rest on your geographic laurels because you will still need to prepare for the shift from traditional Medicare to managed care; just ask the folks in Texas and Arkansas who thought traditional Medicare would last forever. Also you will need to "fine tune" your operations. So, let's proceed then to first provide an overview of managed care followed by mechanisms to eliminate waste and create efficiencies then make suggestions for capital purchasing strategies [or solutions] that will reduce your operational costs while not compromising quality.

Many HME providers have never engaged in discussions with MCOs let alone approached an organization to enter into a contractual relationship to service a patient's home O2 or other DME needs. Some of you, other than maybe your own experience with healthcare, are not familiar with managed health care. In order to proceed lets first review what it *is* and what it is *not*.

Managed health care *is* a system that controls the financing and delivery of health services to members who are enrolled in a specific type of healthcare plan. The goals are to ensure that providers deliver high-quality care in an environment that manages or controls costs; the care delivered is medically necessary and appropriate for the patient's condition; care is rendered by the most appropriate provider; care is rendered in the most appropriate, least-restrictive setting. The major types of managed care plans are Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Point-of-Service (POS) plans.

An HMO enters into contractual arrangements with healthcare providers (e.g., physicians, hospitals, HME providers and other healthcare professionals) who together form a "provider

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network." In simple terms, a contracted provider is one who provides services to health plan members at discounted rates in exchange for receiving health plan referrals. The primary care physician (PCP) is the "gatekeeper" who determines the need for a particular service and patients must be seen by the entities in the network or risk paying additional out-of-pocket fees. A PPO is similar to an HMO in that they enter into contractual arrangements with healthcare providers who together form a "provider network." Unlike an HMO, members don't have a PCP ("gatekeeper") nor do they have to use an in-network provider for their care. However, PPOs offer members "richer" benefits as financial incentives to use network providers. The incentives may include lower deductibles, lower co-payments and higher reimbursements. A POS plan is often called an HMO/PPO hybrid or an "open-ended" HMO. The reason it's called "point-of-service" is that members choose which option (HMO or PPO) they will use each time they seek health care. Like an HMO and a PPO, a POS plan has a contracted provider network. POS plans encourage, but don't require, members to choose a PCP. As in a traditional HMO, the PCP acts as a "gatekeeper" when making referrals. Members who choose not to use their PCPs for referrals (but still seek care from an in-network provider) still receive benefits but will pay higher co-pays and/or deductibles than members who use their PCPs. POS members also may opt to visit an out-of-network provider at their discretion. If so, a member's co-pays, and coinsurance and deductibles are substantially higher.

How is a contract structured with MCOs?

HME providers must develop a better understanding of managed care contracting. An HMO contracts with specific medical groups to provide health services to the members of the health plan for a capitated fee. A capitated fee is a pre-paid, per member fee paid by the HMO to individual physicians to cover health care services to the members of the health plan. So, in the case of a medical group that is at risk for covering all services including DME [oxygen] and other home medical equipment, the HME provider would need to contract with the medical group and/or the health plan directly for local referrals. The patient in this case must use the HME provider that is contracted or risk paying the total cost of the services and equipment out-of-pocket. The HMO and medical group requires demonstration of quality and outcomes because they are scored by accrediting agencies such as National Committee for Quality Assurance (NCQA) and as such must demonstrate that all of the services in their network assure quality and outcomes. So, before you approach a medical group you must be sure to have documentation demonstrating positive outcomes from your service and equipment.

In a PPO, a network of preferred providers is established to provide health care services to the members of the health plan at a reduced fee for the services. The primary difference between an HMO and a PPO is the method of payment to the provider for the service. In the HMO model, all members are referred to the HMO provider, who is paid a capitated amount of money for the provision of these services. In a PPO model a network of providers provide services at a lowered rate to the members of the PPO plan on a fee-for-service payment plan. Fee-for-service payment means that the provider gets paid a pre-set, reduced dollar amount for the services provided to the member. If the member

chooses to go to another provider, they pay larger co-pays for these services, as well as some portion of the bill not covered by the insurance plan. In this case the HME provider contracts with the local medical group and/or the health plan directly (similar to an HMO) however the patient reserves the choice in which provider they ultimately use and if the HME provider is not contracted with the medical group (or in the network) the patient pays larger co-pays or the overall claim. HME providers need to become savvy at contracting with MCOs and this brief overview will not prepare you but should at the least 'wet-your-whistle' and possibly encourage you to buy some yogurt, which may in-turn encourage you to start the yogurt business or simply hire someone who understands managed care contracting.

Operational Efficiency & Capital Purchasing to Reduce Expense

As stated in previous articles HME providers must upgrade (if you haven't already) to enhance the information technology (IT) platform to improve connectivity for claims submission, internal communication to prevent 'time-wasters' and capture important data that will help prepare for pay-for-performance, quality standards and outcomes management. Information obtained through the use of an enhanced IT system help develop marketing materials and evidence-based reports that help with contracting when approaching MCOs.

Expenses for HME providers are typically heavy in labor and operations. So, today's purchasing strategies for oxygen and other equipment must incorporate a return on investment that incorporates a reduction in labor and operational costs. As such, the investment in equipment must include singular solutions to mitigate repetitive visits for services (since services are not reimbursed currently) while not compromising quality of care and meet the therapeutic needs of the patient. With the challenges related to competitive bidding, 36-month cap and ultimate reduction in reimbursement, providers most shift from the traditional approaches of oxygen delivery to an approach that reduces their costs and expense associated with labor. There are many options now available and the options are classified by Williams and McClure (March 2006) in an article they wrote that classifies the differences in the systems as routine oxygen delivery systems or RODS (e.g. Stationary concentrator and aluminum cylinders with or without an oxygen conserving device (OCD); Liquid oxygen (LOX) delivered through one base unit, two base units (tandem system), and one or more liquid portable devices; combination system of one stationary concentrator, one LOX base unit, and one LOX portable unit) or Non-delivery systems which will be referred to as NODS (e.g. devices that manufacture oxygen in the home and provide for portability and/or ambulation through one or more means). Clearly the approach today must focus more on NODS instead of RODS and give non-delivery systems the nod. The challenge however is with identifying a durable system that provides for continuous use and portable use both in and out of the home and meets the need for travel as well as activities of daily living while meeting the therapeutic needs of the patient. The solution must be a singular device to reduce the multiple expensive assets that ultimately are used by patients and require maintenance as well as multiple deliveries which increases operational and labor costs.

There is no clear solution, however those offered here will help an HME provider deal with the challenges created by the MMA of 2003 and prepare for the future to stay in business; unless of course you've decided to open up a yogurt shop.

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