THE NEW COMPETITIVE BIDDING: THE “GAP” PERIOD & PREPARING FOR ROUND 2021

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INTRODUCTION
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- From day one of competitive bidding, the DME industry sounded the alarm that the program would be unworkable
  - “Low-ball bidders” would submit bids in multiple CBAs ... with no ability to take care of patients in those CBAs
  - “Low-ball bidders” wanted to “scoop up as many contracts as possible” in order to have something to sell to losing bidders
  - Because of the “low-ball bidders,” many legitimate bidders would not be awarded contracts
Sounding the alarm (cont.)

- “Low-ball bidders” would drive down reimbursement to a point that contract suppliers (competitive bid “winners”) may not be able to keep their doors open.
- Because CMS would not disclose the standards it used to evaluate the financial condition of bidding suppliers, many otherwise qualified suppliers would be disqualified ... without the disqualified suppliers knowing the basis of their disqualification.
INTRODUCTION

- Sounding the alarm (cont.)
  - Calculation of the Single Payment Amount (“SPA”) would be flawed for a number of reasons, one of which is that half of the winning bidders would be required to accept reimbursement less than what they bid
  - As suppliers shut their doors, access to DME would decrease
  - As a result of lack of access to DME, (i) patients would end up at the ER and (ii) hospitals would be unable to discharge patients because there would be no supplier to take care of the patients upon discharge
And then when the SPAs were extended to rural America and other non-CBAs, the DME industry warned that closure of businesses and lack of access would become even more pronounced

- Rural suppliers had challenges that their urban counterparts did not have, such as having to drive long distances to serve patients
- One of the premises of competitive bidding is that because there will be fewer suppliers in CBAs, then the contract suppliers would be able to compensate for the low reimbursement with higher volume. However, this logic does not hold true in non-CBAs
INTRODUCTION

- Unfortunately, as the government is always inclined to do, it implemented competitive bidding and then “let the carnage begin”

- Until 2018, CMS preached to anyone who would listen that competitive bidding was a resounding success and Medicare beneficiaries incurred no problems because of the program

- But as is often the case, “the real world intervened.” DME suppliers closed their doors, patients did not have access to DME, and physicians and hospital discharge planners were not happy
Finally, in 2018 CMS acknowledged problems with the competitive bidding program. In particular, CMS acknowledged that beneficiaries were having problems accessing DME.

As such, in the late spring of 2018, CMS published a Proposed Rule that substantively changes the competitive bidding program. These are “substantive” changes ... not window dressing.

Subsequently, CMS published its Final Rule, which is substantially the same as the Proposed Rule.
ROUND 2021

- March 7, 2019
  - CMS announced that Round 2021 has been announced and is scheduled to begin on 1/1/2021

- May 2019
  - CMS announces dates for registration and bidding
  - CMS begin bidder education program
ROUND 2021

- June 2019
  - Bidder registration period to obtain user IDS and passwords begin
  - Bid windows open
ROUND 2021

- Consolidated the competitive bidding areas ("CBA") included in Round 1 2017 and Round 2 Recompete
- 130 CBAs — table on CMS website
ROUND 2021

- Product Categories
  - Commode Chairs
  - Continuous Positive Airway Pressure (CPAP) Devices and Respiratory Assist Devices (RADS)
  - Enteral Nutrition
  - Hospital Beds
  - Nebulizers
  - Negative Pressure Wound Therapy (NPWT) Pumps
Product Categories (cont.)
- Non-invasive Ventilators
- Off-the-Shelf Back Braces
- Off-the-Shelf Knee Braces
- Oxygen and Oxygen Equipment
- Patient Lifts and Seat Lifts
- Standard Manual Wheelchairs
- Standard Power Mobility
Product Categories (cont.)
- Support Surfaces (Groups 1 and 2)
- Transcutaneous Electrical Nerve Stimulators (TENS) Devices
- Walkers
Surety Bond — CMS Fact Sheet is available
- Required to obtain a surety bond for $50,000 in each CBA
- Must be purchased from a Department of Treasury List of Certified Companies
- Must provide by close of bid window
- Should upload a copy into Connexion
ROUND 2021

- Lead Item Pricing
- 16 product categories
- One lead item has been identified
- The item with the highest total allowed charges nationwide
ROUND 2021

- Single Payment Amount for the lead items is the maximum bid submitted for that item by suppliers whose bids for that item are in the winning range for the CBA
- SPAs for other items in the product category are determined by applying a relative ratio
- Ratios are based on historic differences in the fees schedule amount for the lead and non-lead items
ROUND 2021

- Relative Ratio
  
  Average of historic unadjusted fee schedule amounts for non-lead item – lead item HCPCS code
  
  Average of the historic unadjusted fee schedule amounts for the lead item HCPCS Code

- Lead Item Pricing Calculator
ROUND 2021

- Other Fact Sheets
  - Licensure for Bidders Fact Sheet
  - Process for Reviewing Covered Documents Fact Sheet
  - Required Financial Document Fact Sheet
  - What’s New Fact Sheet
- Precluded Suppliers
“GAP” PERIOD
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- The existing Round One 2017 and Round Two Recompete came to an end on 12/31/18
- Competitive bidding went on a hiatus that will last for approximately 24 months beginning with 1/1/19. This hiatus is known as the “gap” period
JUMPING BACK INTO THE MEDICARE MARKET
Assume that ABC Medical Equipment, Inc. is located in a CBA but does not currently have a competitive bidding contract. As a result, assume that ABC’s business model looks like the following:

- ABC sells non-competitive bid items to beneficiaries for cash
- ABC sells competitive bid items to beneficiaries for cash ... only after obtaining an ABN
JUMPING BACK INTO THE MEDICARE MARKET

• ABC has secured hospice contracts, SNF contracts, Medicare Advantage Plan contracts, and Medicaid Managed Care Plan contracts
• In short, ABC has walked away from Medicare fee-for-service (“FFS”)
JUMPING BACK INTO THE MEDICARE MARKET

- The question becomes: Should ABC jump back into the Medicare FFS market during the “gap” period? Let us examine the “pros and cons”
  - Medicare FFS is tantamount to an “addiction.” ABC is currently “clean and sober” ... it is not billing Medicare FFS
JUMPING BACK INTO THE MEDICARE MARKET

• As a result of not billing Medicare FFS, ABC may have less gross income, but ABC does not have to deal with audits and does not have to incur the expenses of meeting the myriad Medicare requirements. To an extent, ABC’s life is “simple” and it is predictable.

• During the “gap” period, ABC may have a reflexive Pavlovian urge to start billing Medicare FFS. Logically, it may not make sense for ABC to do so, but ABC might be saying to itself: “I am a DME supplier. Therefore, I should bill Medicare FFS.”
JUMPING BACK INTO THE MEDICARE MARKET

- Pros and cons ...
  - ABC needs to avoid such an emotional response and, instead, look at the issue objectively. If ABC has been able to sustain its business without Medicare FFS, then ABC should ask itself: “Why should I torture myself by jumping back into the Medicare FFS fray? Why should I fall off the wagon and start feeding my addiction again?”
JUMPING BACK INTO THE MEDICARE MARKET

- Pros and cons …
  - On the other hand, ABC may desire to once again become “one stop shopping” for physicians and other referral sources. Even if ABC only breaks even on Medicare FFS, it may determine that it is worth it because being “one stop shopping” for referral sources will open up increased non-Medicare FFS business.
JUMPING BACK INTO THE MEDICARE MARKET

- Pros and cons ...
  - If during the gap period, ABC loads itself up with oxygen patients, other rental/capped rental patients, and other recurring patients who take products that will be covered by competitive bidding when the program starts up again, then ABC needs to understand that if it is not awarded the upcoming contract, it (i) may lose these patients, (ii) may not be able to take on additional patients covered by competitive bidding, and (iii) may anger referral sources who got used to using ABC as a “one stop shop”
JUMPING BACK INTO THE MEDICARE MARKET

Pros and cons ...

- If during the gap period, ABC loads itself up with patients who are purchasing/renting products that normally would be covered by competitive bidding, and if ABC loses these patients because ABC is not awarded the upcoming competitive bid contract, then ABC will still be subject to potential audit liability long after these patients vanish.
JUMPING BACK INTO THE MEDICARE MARKET

- Pros and cons ...
  - During the gap period, perhaps ABC can serve Medicare FFS patients ... in a limited way
  - For example, if it has not already done so, ABC can elect to be non-participating. In doing so, then during this gap period, ABC can provide covered items on a non-assigned basis. This means that ABC can require the patient to pay cash up front to ABC. Thereafter, ABC will submit a claim to Medicare on behalf of the patient ... and Medicare can reimburse the patient for 80% of the Medicare allowable
JUMPING BACK INTO THE MEDICARE MARKET

- Pros and cons ...
  - By providing covered items on a non-assigned basis, then ABC will essentially be treating the patients as cash/retail patients. ABC will not have to deal with receivables from Medicare.
  - Note that in providing covered items on a non-assigned basis, ABC will be subject to potential Medicare audit liability. However, ABC will be getting its cash up front.
EXITING COMMON OWNERSHIP ARRANGEMENTS
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- During the Round One 2017 and Round Two Recompete rounds, a number of DME suppliers entered into common ownership arrangements
  - A non-contract supplier would purchase 5% or more of a contract supplier … or vice versa. With the CBIC’s approval, the non-contract supplier would be added as a supplier to the contract supplier’s existing competitive bid contract
  - Now that we are in the “gap” period, parties to common ownership arrangements need to ask themselves if they want to unwind the arrangements
EXISTING SUBCONTRACT ARRANGEMENTS
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During the Round One 2017 and Round Two Recompete rounds, a number of DME suppliers entered into subcontract arrangements

- Under a subcontract arrangement, (i) a contract supplier might handle intake and other functions expected of a supplier, while (ii) a non-contract supplier will handle the delivery, set-up, and patient education. The contract supplier ("contractor") will pay the non-contract supplier ("subcontractor") for its services
- Now that we are in the “gap” period, parties to subcontract arrangements need to ask themselves if they want to unwind the arrangements
FUTURE COMMON OWNERSHIP/SUBCONTRACT ARRANGEMENTS
FUTURE COMMON OWNERSHIP/SUBCONTRACT ARRANGEMENTS

- If an existing non-contract supplier decides that it will submit a bid for the next round (presumably to start on 1/1/21), then the supplier needs to ask itself what it will do if it is not awarded a contract
  - In advance of submitting a bid for the next round, the supplier may want to start talking to other suppliers about entering into a common ownership or subcontract arrangement if one of them is not awarded a contract
PAYMENTS IN FORMER CBAS DURING GAP PERIOD
PAYMENTS IN FORMER CBAS DURING GAP PERIOD (NON-DIABETIC SUPPLIES)

- During the gap period, reimbursement is the SPA + inflation increase.
- Reimbursement for mail-order diabetic supplies is the SPA plus the inflation increase for the preceding 12 months ... with an additional increase at the end of each 12 months thereafter.
- Reimbursement for non-mail order diabetic supplies is at the current SPA.
RURAL/NON-CONTIGUOUS AREAS
RURAL/NON-CONTIGUOUS AREAS

- Reimbursement is the current higher 50-50 blended rates
NON-RURAL/NON-CBA
NON-RURAL/NON-CBA

- Reimbursement is the lower 100% adjusted fee schedules that are based on bid rates
- These rates will be adjusted in 2020 with a small inflation index
QUESTIONS?
THANK YOU

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