

May 2009

## CMS EXPLAINS MANDATORY SURETY BOND REQUIREMENT

*PMC Urges All HME Providers to Start Researching Bond Underwriters*

On March 17, 2009, the Centers for Medicare and Medicaid Services (CMS) hosted a special Open Door Forum (ODF) on the mandatory surety bond requirement for home medical equipment (HME) providers, including providers of power mobility devices (PMDs). Participation was via telephone only. Natalie Highsmith of CMS' Office of External Affairs moderated the forum.

In late December, 2008 CMS announced that it was requiring certain DMEPOS suppliers to post a surety bond in an amount not less than \$50,000. Existing suppliers subject to the bonding requirement must



comply with this requirement by October 2, 2009, while newly enrolling suppliers subject to the bonding requirement must meet this requirement by May 4, 2009. A copy of the final surety bond rule can be found at:

Frank Whalen, CMS' representative in charge of directing the HME surety bond provision stated that if bond documentation is not provided to the National Supplier Clearinghouse (NSC) with a new provider's 855 NSC application by the required date, the application will be rejected. Existing suppliers who do not provide proper surety bond documentation to the NSC by October 2nd will have their provider number

automatically terminated. There will be no specific bond form, but bond documentation

should include signed certificates from the underwriter indicating that the provider as the principal and CMS as the obligee.

The bond amount is at least \$50,000 for each national provider identifier (NPI)



issued to the HME provider. Providers, moreover, can obtain a single bond for multiple NPIs. Providers who have had an "adverse action" in the past ten years will need to get an additional \$50,000 bond for each adverse action. These bonds will be in addition to, not in lieu of, the initial \$50,000 bond.

As specified by the rule, adverse actions are defined as:

- (i) A Medicare-imposed revocation of any Medicare billing privileges;
- (ii) Suspension or revocation of a license to provide health care by any State licensing authority;
- (iii) Revocation or suspension by an accreditation organization;
- (iv) A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(A)(i)) within the 10 years preceding enrollment, revalidation, or re-enrollment; or

(v) An exclusion or debarment from participation in a Federal or State health care program.

A corporate integrity agreement entered into with government or law enforcement would not be considered an “adverse action” for the purpose of obtaining a surety bond.

HME providers must use approved surety underwriters, a list of which can be found at: [www.fms.treas.gov/c570/c570\\_az.html](http://www.fms.treas.gov/c570/c570_az.html). Some underwriters may not offer bonds to all HME providers or may offer a bond at a higher cost.

A new 855 NSC Application reflecting the bond requirement will be released in the next couple of weeks and providers must use the form immediately after its release.

Many questions regarding the bond requirement, especially questions centering on exemptions to the bonding requirement, are still pending. To answer some of these questions (as well as others), CMS is drafting a FAQ on the surety bond rule. It



will soon be posted at: [www.cms.hhs.gov/medicareprovidersupenroII/](http://www.cms.hhs.gov/medicareprovidersupenroII/). In addition, an MLM article on surety bonds is also being developed. Specific provider questions can also be directed to CMS staffer Frank Whelan at [frank.whelan@cms.hhs.gov](mailto:frank.whelan@cms.hhs.gov).

The PMC urges all HME providers to start contacting CMS-approved bond underwriters to start the process and have a better understanding of the costs associated with the new bonding rule. As always, feel free to contact me if you have any questions or need further information.

## **PMC URGES CMS TO RESCIND BIDDING PROGRAM**

*Mandatory Provider Consolidation will Result in Restriction to Access and Job Loss*

The following are excerpts from comments on the interim final rule implementing the Medicare Improvement for Patients and Providers (MIPPA) submitted by the PMC to CMS:

In order to avoid the pitfalls experienced in the aborted first round of bidding, the PMC makes the following recommendations:

- **Rescind the IFR and Reissue the Regulation as a Proposed Rule Subject to Meaningful Notice and Comment**

CMS lacks the authority to issue the regulation as an IFR. The IFR bypasses the traditional notice and comment process required by both the Social Security Act and the Administrative Procedure Act. 42 U.S.C.S. § 1395hh(a)(2); 5 U.S.C.S. § 553. While CMS may issue an IFR if it finds notice and comment procedures to be “impracticable, unnecessary, or contrary to the public interest,” such “good cause” has not been established in this instance. 5 U.S.C.S. § 553(b)(B).

While CMS asserts good cause under the theory that it would be both impracticable and unnecessary to undergo the traditional rule making. 74 Fed. Reg. 2873, 2878. The statutory deadline for implementation of



competitive acquisition is 2009 with no specific date required, leaving adequate time for notice and comment procedures to be followed. Further, Congress’ decision to suspend and delay the initial round of

bidding demonstrates a need for further discussion. Implementing a rule without soliciting input from stakeholders prevents CMS from properly examining the problems which plagued the aborted first round of bidding and led to the Congressional action that delayed the program.

The initial round of competitive bidding was marred by significant problems at almost every step in the process. These problems



included: glitches that marred timely provider enrollment, provider bids being unfairly disqualified and accusations of providers gaming the bidding process in certain product categories. Proper notice and comment would ensure that HME stakeholders have the ability to publicly identify problems in the bidding process and make recommendations to ensure that past is not prologue in regards to implementation of the program. As a result, the PMC is urging CMS to rescind the IFR and, at a minimum, reissue the regulation as a proposed rule subject to meaningful notice and comment.

- **Require Providers to be Accredited Prior to Bidding**

The PMC is very supportive of CMS' mandatory accreditation requirement which will require all providers who participate in



the Medicare program be accredited by a nationally recognized accreditation body by October 1, 2009. Such standards are imperative to preserve program integrity and ensure that there is a meaningful barrier of

entry into the Medicare program for lawful providers. Yet, under the IFR, it is our understanding that CMS will allow non-accredited providers to, in the initial round, bid upon a "promise" that they be accredited by the required date.

Program integrity is paramount to ensure Medicare beneficiaries receive the highest quality of products and services from lawful providers. Stringent quality standards coupled with mandated accreditation of providers will rid the Medicare program of unscrupulous actors and reinforce the integrity of those providers who play by the rules.

Allowing non-accredited providers to participate in the bidding process is contrary to CMS' priority to safeguard Medicare resources and beneficiaries. Allowing non-



accredited providers to bid and be awarded contracts will cause major disruption if the contracted provider (or subcontractor) cannot obtain accreditation and the contract must then be terminated and subject to a rebid. In addition, non-accredited providers will have lower overhead and, as a result, would be able to submit lower bids which could artificially lower single payment amounts for accredited contracted providers.

- **Establish Safeguards to Deter Providers from "Gaming" the Bidding Process**

Unscrupulous actors could undermine the bidding process by bidding at an unrealistic low rate to ensure inclusion in the market. Unfortunately, this strategy could artificially

lower the single payment amount, making it difficult for all winning providers to serve beneficiaries at such reduced rates. The Competitive Bidding Independent Contractor (CBIC) must be on the lookout for bids that are well-below the historical fee schedule amount and be leery of providers trying to undercut the market rate just to gain market share.

Several PMC members have relayed stories of bidding anomalies in the aborted first round. In fact, the single payment amount for PMDs in several bidding Metropolitan Statistical Areas (MSAs) were well below the wholesale price. Many reputable providers questioned the validity of such



bids given the limited experience of the winning bidders. In addition, long serving providers had issues at whether these chosen providers could meet the volume required under the contract. One theory is that these winning providers had no intent of filling the contract and was only interested in getting a winning contract so that they could sell their business at a premium to a reputable provider who has an interest in serving that MSA.

Unfortunately, the breadth, scope and extent of such gaming will never be fully examined since the IFR requires no meaningful input from impacted stakeholders. If fully analyzed, CMS would realize the need to safeguard the bidding process from such gaming. Some of these safeguards could include establishing a bidding floor (to ensure a “proper” reimbursement level) or auditing winning bidders prior to awarding

the Medicare contract to ensure they can meet minimum volume requirements of the MSA.

- **Extend Expedited Appeal Rights to Non-Winning Providers**

Under the competitive bidding rules, providers have no administrative or judicial review for “the awarding of contracts” under the competitive bidding program.

The PMC has concerns that CMS can conduct the competitive program without any opportunity for administrative or judicial oversight of the process. Considering the number of procurements that are set aside each year by the General Accountability Office (GAO) and the United States Court of Federal Claims based upon government error, it is inconceivable that CMS would even suggest such a secret and insulated process. This is a recipe for arbitrary and erroneous awards.

Providers who have a reasonable grievance should be able to challenge a determination



of the CBIC before an independent entity or Administrative Law Judge to ensure fairness and due process. Providers will be staking resources and, in certain instances, survival of their business on contracts awarded by the CBIC. As a result, providers must be afforded the right to contest questionable determinations. Further, to ensure no disruption in HME services to beneficiaries, any independent appeals process must be expedited.

As a result, the PMC recommends that Congress require any competitive bidding program to be subject to the traditional judicial review of procurements conducted by the government.

- **Provide COLA Increase for Single Payment Amounts**

CMS should allow for cost of living adjustments (COLAs) to single payment amounts determined under the bidding process. COLA



increases will ensure that providers are fairly compensated if costs increase as a result of inflation

or other economic pressures. Such an adjustment, moreover, will ensure that providers won't have to cut back on quality or services in order to continue participation in the Medicare program and will aid suppliers in meeting capacity targets set out in the bidding contracts.

- **Monitor Provider Capacity and Allow the CBIC to Make Mid-Course Corrections**

At a hearing on competitive bidding before the House Ways and Means Committee, the General Accounting Office (GAO) recommended that CMS closely monitor competitive bidding, through beneficiary and provider surveys and other oversight, to ensure access and that contracted provider's meet capacity. The PMC recommends that CMS give the CBIC the authority to contract with new providers if GAO reports potential beneficiary access issues as a result of providers failing to meet capacity for a particular product in a particular MSA.

- **Require at Least a 10% Savings Before an HME Item Can be Subjected to Competitive Bidding**

Given the costs to the Medicare program in establishing and implementing the competitive bidding program, the PMC recommends that CMS exempt those items and services for which the application of competitive bidding is not likely to result in significant savings of at least 10%. This will ensure the outlays made by the Medicare in implementing a bidding process will pay off in a net savings to the program.

- **Prohibit CMS from Extending Single Payment Amounts Beyond Competitive Bidding Areas**

Under competitive bidding rules, CMS has the authority to extend single payment amounts for HME items to areas that have not been subjected to competitive bidding after 2009. The PMC recommends that Congress repeal this authority since



reimbursement reductions in rural or underserved areas will further exacerbate

beneficiary access and jeopardize the mostly small, "mom and pop" operations that serve these communities. HME providers who serve rural and underserved areas have to travel great distances to service beneficiaries and often their costs are higher since they serve fewer patients and cannot take advantage of volume discounts on HME products.

- **Competitive Bidding Should Have No Impact on a**

## **Provider's Ability to Change Ownership**

While CMS has a fiduciary duty to ensure that every provider is accredited and meets quality standards, CMS cannot deny contracted provider status, or unreasonably withhold its approval of new ownership, on the basis that the new ownership may not meet the capacity stated in the contract. Contracted providers in competitive bidding areas will most likely experience an increase in the value of their businesses and, therefore, should be able to take advantage of the market place without interference from government agencies, if they wish to lawfully transfer ownership.

- **Establish a Serial Number Tracking Program for HME Items**

CMS has characterized competitive bidding as an additional anti-fraud tool. Since the late 1990's, the agency has testified to Congress that more needed to be done to address fraud and abuse. In 2001, former Health and Human Services (HHS) Inspector General, June Gibbs-Brown testified to



Congress that the two primary issues the Medicare faces with HME providers is paying for products never delivered and/or paying for more expensive items than what was actually delivered to the Medicare beneficiary.

Rather than punitively punishing legitimate providers by drastically reducing the fee schedule, the PMC recommends that CMS establish a serial number identification program that can track individual HME items through the claims process. Under

such a system manufacturers of HME could report serial numbers to be included in a CMS data base. Providers would then have to include the serial number on their claims, allowing CMS to monitor and track supplies from manufacturer to provider to beneficiary.

Access to high-quality HME allows Medicare beneficiaries to live independently and out of more costly institutional settings. As such, the PMC believes that HME is an essential component to any health care reform effort and that



beneficiary access to HME will lead to Medicare cost savings and better medical outcomes for American seniors and those with disabilities.

The PMC continues to have concerns with government acquisition program that will eliminate jobs, encourage the purchase of foreign products, and reduce quality healthcare. We appreciate the opportunity to offer these comments and look forward to working with CMS on this and other issues of mutual interest.

### **SUMMARY OF CMS' April ODF on HH, Hospice and DME**

On Wednesday, April 1st, the Centers for Medicare and Medicaid Services (CMS) hosted an Open Door Forum (ODF) on Home Health, Hospice and Durable Medical Equipment (DME). Natalie Highsmith of CMS' Office of External Affairs moderated the forum.

The following were issues discussed that are of importance to power mobility device (PMD) suppliers:

### Accreditation

CMS officials continued to urge HME providers to start the application process for accreditation to ensure that there is enough time for an application review and an on-site visit. All HME providers must be accredited by September 30, 2009 or risk revocation of their billing number. CMS announced the release of a new DME provider enrollment form, 855S, that can be found at: [http://www.cms.hhs.gov/MedicareProviderSupEnroll/02\\_EnrollmentApplications.asp#TopOfPage](http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp#TopOfPage). Currently, providers can use either the old or revised form but the new form must be used by all providers as of June 1, 2009.

### Competitive Bidding

CMS provided no new news on competitive bidding other than to remind providers that the interim final rule goes into effect on April 18th. CMS is still evaluating a timeline which will ensure implementation of the first round of bidding by the end of the year as required by Congress.

### HME Surety Bond

A provider that has an application for a new NPI pending with the NSC by May 4th will be required to be bonded prior to the issuance of a supplier number. In all cases, the provider will be responsible for contacting an underwriter to get a bond.



The underwriter will most likely require financial statements (both corporate and personal) and the provider's NPI application with the NSC. Underwriters

have told CMS that it should take 15 days from the time they receive all needed

documentation from the providers until they can make a determination whether to issue a bond. Providers must then submit the bond approval to the NSC prior to October 1st. A FAQ has been posted at: <http://www.cms.hhs.gov/medicareprovidersupenroll/>

### Recovery Audit Contractors (RACs)

The contractor issues have been resolved and the "stop order" on the RAC program has been lifted. CMS will be conducting outreach in the upcoming weeks. A Special



ODF RACs for Part B providers (including providers of PMDs) is scheduled for April 14th.

Providers with questions on the RAC program can submit them via e-mail at [rac@cms.hhs.gov](mailto:rac@cms.hhs.gov).

### On-Line Application

CMS has launched an online application process for most providers with the exception of DMEPOS. CMS hopes to have a DMEPOS online application up sometime in 2010.

The next Home Health, Hospice and DME ODF is scheduled for June 3rd. The PMC will provide you with details on how to participate once they become available.

### **PMC CALL TO ACTION TO RECID BIDDING**

*All HME Stakeholders Urged to Contact their Member of Congress during the Spring Recess*

With Congress on the verge of a district work period, now would be an opportune

time for power mobility devices manufacturer, suppliers and beneficiaries to meet with their Congressional representatives and urge them to rescind the competitive program for the top nine categories of home medical equipment (HME). The District Work Period extends from May 25-29 and many of Members of Congress (MoC) will be holding town hall meetings, appearing at public forums or speaking before local business and social groups. Some MoC will be holding "open houses" at their District offices to specifically hear constituent concerns.



The PMC urges all HME stakeholders to take advantage of these opportunities to inform their Congressional representatives of the dangers of competitive bidding. As HME suppliers are well aware, implementation of competitive bidding will restrict beneficiary access to quality HME, lead to thousands of suppliers losing jobs through mandatory consolidation of the industry and creates incentives for those suppliers who are still in the program to purchase inferior HME from overseas vendors. For a more detailed list of PMC's concerns with the competitive bidding program, see the article in this edition of Coalition Corner entitled, *PMC Urges CMS to Rescind Competitive Bidding Program*.

HME stakeholders can find information on where their MoC may be appearing by checking their website or calling their offices. Websites can be accessed through [www.thomas.gov](http://www.thomas.gov) and Congressional offices can be contacted through the Capitol switchboard at 202-225-3121. Please note,

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absent Congressional intervention, competitive bidding will be rolled out this year and it becomes significantly more difficult to get a program rescinded once it's been implemented.

***Around the Beltway:*** President Obama has nominated Gov. Kathleen Sebelius (D-KN) to be Secretary of Health and Human Services and former Health Care Financing Administration (HCFA) Administrator



Nancy Ann DeParle as White House Office for Health Reform. The Senate voted on Sebelius' nomination and passed 65-31.

DeParle, who headed HCFA during the Clinton Administration, does not need Congressional approval and is already serving in her new post. HME providers, including provides of power mobility devices, enrolled in the Medicare Part B program are required to obtain accreditation by **September 30, 2009**. A new MLN Matters Special Edition article on this subject is now available. The article outlines what you need to do if you have not yet complied with the



Medicare program's supplier standards and quality standards to become accredited. To view the MLN Matters article, go to: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf>.