

A MOST SERIOUS THREAT TO YOU AND YOUR PATIENTS LOOMS LARGE – POST ACUTE CARE BUNDLING MAY BE TARGETED TO PROVIDE THE DOLLARS FOR ‘DOC FIX’ AT O&P’S PERIL

We wanted to advise you regarding a relatively new, potentially very serious threat to O&P Medicare reimbursements, and actions AOPA is taking to move proactively to eliminate or markedly reduce this threat. Congress is in the process of considering a permanent “doc fix,” i.e., eliminating the so-called SGR, or sustainable growth rate formula which consistently triggers significant legally-mandated reductions in the Medicare physician fee schedule. This effort may or may not ultimately be successful, but if it does go forward, Congress will need to identify \$130 billion of new Medicare cuts to ‘pay for’ this permanent doc fix. The prime means to find these moneys has been identified as the implementation of ‘post acute care bundling’—whereby Medicare would make a single (reduced) payment to one contracted entity, e.g., it might be a rehab hospital, which would then sub-contract in a “low bid” type process, to provide all services for that patient for the first 90 days after discharge from the hospital. CMS has already initiated some demonstration projects on post acute care bundling, and Congressional staff believe this can alone generate \$100 billion of the needed savings.

How AOPA Has Responded to the Threat of Post Acute Care Bundling for O&P

According to the draft language, physicians and therapists would be exempted from the bundle. AOPA has pressed staff for a similar exemption for prosthetists and orthotists, citing that the amount of these costs would skew any bundle and that the 90-day period was incompatible with the longer term nature of O&P services/needs. Initially, we met opposition with the response that prosthetics and orthotics will be part of the bundle. We made some progress by making clear that we are not simply talking about braces or artificial limbs as commodities, but that we are talking instead about how **post acute care bundling would remove the right Medicare beneficiaries currently enjoy to choose the health care provider who will be engaged in what is usually a lifelong relationship to help address the patient’s mobility needs.** We also noted that Congress had already provided clear indication that this patient choice and the provider relationship need to be protected by virtue of how Congress excluded from competitive bidding all O&P, with the exception of off-the-shelf orthotics. AOPA reps were told that we needed to submit proposed language to address these issues to the requisite Congressional staff by the end of this week, i.e., by February 28.

You will see below the language AOPA has submitted. Time was very short, but AOPA has worked in conjunction with the O&P Alliance and we have secured general support from the members of the O&P Alliance for this approach. Regardless of whether a permanent SGR fix is enacted with immediate post acute care bundling, or whether the doc fix does not advance, post acute care bundling IS a topic of dramatic importance/potential impact on orthotics and prosthetics. Large scale adoption of post acute case bundling, that is, if all O&P were included in the bundle, would be devastating for the profession. There would almost certainly be great reduction in competition and large blocks of business/patient care would be allocated to the ‘low bidder.’ AOPA hopes that the view/language similar to that below will carry the day, and we are committed to a strong fight on this issue so critical to our O&P professionals and the patients that they serve. We will keep you informed.

Rationale: *Prosthetics and orthotics (artificial limbs and orthopedic braces) are very different from durable medical equipment (DME) inasmuch as it is not the distribution of commodities; rather orthotic and prosthetic care involves an ongoing series of clinical services provided by licensed and/or certified professionals which results, through the use of devices, in the ability to regain or maintain ambulation and full function. Under the present Medicare structure, beneficiaries with limb-loss or limb-impairment are permitted to choose the licensed and/or certified health care professional with whom they establish a patient care relationship. Importantly, as limb-loss is a permanent condition, this relationship is generally established for the patient's entire life. The patient has the right to choose a provider with whom they are comfortable and who best addresses their mobility needs. This clearly is a relationship that needs to be based on more than just a lowest-bid contractual relationship.*

As we indicated in our meeting, there is a history which argues strongly in favor of the broadest exemption of prosthetics and orthotics from post acute care bundling to protect the prerogatives and quality of care interests of these patients. Past experience with hospital DRGs and with SNFs illustrated that patterns developed whereby providers responded to comparable bundling by delaying and denying O&P patient care until the patient was discharged when it was clear that Medicare Part B assumed the cost of O&P treatment. Patient quality of care declined with these inappropriate delays in access to O&P care, often irreversibly compromising independent living and relegating the patient to nursing home care. It is imperative to avoid this damage to these mobility compromised patients, which is a compelling reason why the best resolution is to exempt prosthetics and orthotics from the PAC bundle.

In addition, Congress and CMS have determined that competitive bidding is an ill-suited means of providing complex O&P care to Medicare patients. Similarly, bundled payments are poorly suited for the delivery of custom O&P care because the devices and related clinical services are of a unique nature that is not appropriately captured by a system that relies on a comparison between what may seem to be similar or substitute items and services. To include O&P in bundling would be a radical change to the Medicare system, and catastrophic for these limb-impaired individuals if adoption of post acute care bundling interrupted those existing patient care relationships or denied Medicare beneficiaries the right to choose their prosthetist/orthotist.

Fortunately, Congress has previously addressed this issue in an appropriate manner when in 2003 Congress exempted all prosthetics and custom orthotics from Medicare competitive bidding. Congress limited competitive bidding to only "off-the-shelf orthotics," which Congress further defined as devices which could be used by the patient with "minimal self-adjustment" and which do not require any expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. The number of "off-the-shelf" orthotic devices is limited both in number and in potential savings from bidding and/or bundling.

We believe the bundling bill you propose would best serve beneficiaries by simply exempting O&P care from the bundled payment and preserving the licensed and/or certified prosthetist/orthotist relationship in the same way you are protecting the patient/beneficiary's right to select his/her physician, physical/occupational/speech therapist. That would be the safest route to protect these limb-loss/limb-impaired Medicare beneficiaries. If the Committee chooses not to afford beneficiaries similar protections in their choice of the health professional committed to their lifetime mobility care, then we have offered an alternative in language, albeit much less desirable, which would address these patients vis-à-vis post-acute care bundling in parallel to and consistently with the policy Congress already adopted as to competitive bidding authority.

A. Proposed and Preferred Statutory Language:

*“(B) EXCEPTIONS.—Such term does not include—
“(i) physicians’ services;
“(ii) hospice care;
“(iii) outpatient hospital services;
“(iv) ambulance services;
“(v) outpatient physical therapy services; and
“(vi) “prosthetics and orthotics” as defined by Section 1861 (s)(9)*

B. Alternative, less preferable because it is more intrusive to patients, to follow the pathway Congress set in competitive bidding:

*“(B) EXCEPTIONS.—Such term does not include—
“(i) physicians’ services;
“(ii) hospice care;
“(iii) outpatient hospital services;
“(iv) ambulance services;
“(v) outpatient physical therapy services; and
“(vi) prosthetic and orthotic devices and services, with the exception of those off-the-shelf orthotic devices if
(a) CMS has included such devices in an actively operating competitive bidding program under section 1861(s)(9);
(b) A list of such off-the-shelf orthotic devices has been published pursuant to final notice and comment rulemaking under 5 U.S.C. § 500 et seq.; and
(c) In developing the list of such devices, the Secretary uses a strict definition and criteria of off-the-shelf devices established in Section 1847 (a)(2), consistent with section 1834(h). “*

(Section 1847 (a)(2) defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Social Security Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.)