A TOPIC AOPA IS WORKING ON THAT IS IMPORTANT TO THE FUTURE OF YOUR BUSINESS

Pending Debt Limit/Sequestration/Expiring Funding Resolution Pose Significant Threats to O&P Medicare Fee Schedule Reimbursement, including Risk of Expansion of Medicare Competitive Bidding

The Core of the Issue

Over the next ten weeks, we have a virtual 'hat trick' of Congressional deliberations slated which, because of their focus on potential government spending cuts and debt reduction, pose a very substantial risk to all Medicare providers, including O&P patient care facilities and suppliers. (1) Congress enacted a delay until May 19, but action will be required within the next 120 days to raise the debt limit or the U. S. will default on its payment obligations. (2) Hearkening back to the August, 2011 agreement upon the last debt limit legislation, approximately $1 trillion in cumulative payment cuts over a ten year period are due to kick in on March 2, as a result of a mechanism called sequestration. Medicare enjoys a special limitation of 2% under that statute, but many in Congress want to extract more of the savings from Medicare. It appears, at the minimum, i.e., if there is no change and sequestration kicks in, it will result in a 2% across the board reduction in the Medicare fee schedule, which translates into what would be an immediate reduction of around $40-50 million annually in O&P reductions. The third item relates to the fact that the present 'continuing resolution' that keeps the government operating will expire in late March, so new action—which could include potential additional Medicare spending cuts—will be required to avert a shutdown of the federal government.

Why Is It Important To You?

The bad news is that a cut of $40-$50 million annually is the baseline, but the risks of much deeper cuts loom. And more bad news as to potential Medicare cuts is that it seems that things like premium changes/increases, or other charges to beneficiaries will be off-the-table in the across-the-board structure, so the amount to be extracted from Medicare would be made up virtually entirely in provider payment cuts. Odds are that Medicare providers (and O&P) will likely do better if sequestration kicks in unchanged. If there are changes to the sequestration formula, there are risks of even greater fee schedule reductions and even risks of greater, more disastrous structural change for our patients, i.e., changes to expand competitive bidding.

What Is AOPA Doing About This?

We have been very concerned with overly simplistic and under-informed communications which have recently appeared in the name of the Center for America Progress (CAP). CAP essentially has argued for universal competitive bidding expansion to encompass every medical device made available to beneficiaries in the Medicare program, and offers the promise that doing so would save the government $38 billion. This is a very tantalizing idea put forward in a delicate time when fiscal cliff/sequestration deliberations could trigger quick attention to a promise of such extensive potential savings. Unfortunately, such universal reliance on competitive bidding would result in devastating interruptions and disorientation of the care of Medicare beneficiary amputees, and of similarly situated beneficiaries with limb impairment from chronic conditions like multiple sclerosis, cerebral palsy, scoliosis, spina bifida and others—patients whose mobility is severely threatened and who rely on ongoing prosthetic and orthotic care to maintain their independence. CAP clearly does not understand that prosthetics for an amputee is more than a simple commodity such as a walker or a cane, it is a medical device that is attached to a person's body and use of the prosthetic device involves a great deal of fitting as well as health care intervention by a provider they trust and who understands their needs. This is what would be lost by treating prosthetics and custom orthotics like a cane or a walker.

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Let's take stock of three essential facts that currently prevail relating to Medicare competitive bidding:

1. Federal law limits competitive bidding in orthotics and prosthetics so that it can apply only to off-the-shelf orthotics.
2. That same statute establishes a definition for off-the-shelf orthotics which states that to qualify a device must be capable of use by the patient "with minimal self-adjustment."
3. CMS has chosen, to date, not to include 'off-the-shelf orthotics' in either Rounds 1 or 2 of competitive bidding (nor was it included in the re-bid of Round 1), but it has published a proposed list of 'off-the-shelf orthotics' which is overly aggressive, including a substantial number of devices that clearly do not meet the 'minimal self-adjustment' aspect of the statutory definition. AOPA has communicated 479 pages of comments to CMS on this, which includes a letter from legal counsel noting that ignoring the statutory limitation of "minimal self-adjustment" would invite a challenge from AOPA by litigation. The O&P Alliance also submitted parallel comments, and the Alliance met with key CMS leaders on this, showing specific devices on the CMS list and explaining why those devices do not meet the criteria in the statute's definition.

So, any effort to expand competitive bidding for O&P would almost certainly necessitate action by Congress to amend the current law.

We have all witnessed too many times these 'near-midnight' actions by Congress to quickly pass a bill, the provisions of which are not very familiar to the members of Congress. This creates the ideal environment for faulty decision-making, and it is precisely in this type of environment where the temptation of purported big savings could prompt imprudent legislation on competitive bidding. We were deeply troubled within the past two weeks when the Center for America Progress proposal on greatly expanded competitive bidding (including O&P) was referenced favorably in a *Washington Post* editorial about ways to generate savings.

AOPA has taken early action to make sure members of Congress are fully aware of the disastrous consequences that would flow for our patients from expanding competitive bidding to include a bigger slice of O&P. In December, AOPA joined with the Amputee Coalition in sending a detailed letter that was delivered to every member of Congress explaining why this would be horrible policy. We are continuing our work and advocacy and are in the process of visiting key staff for all of the key Medicare committees to assure that they understand that expanded competitive bidding would mean elimination of clinical care for Medicare amputees and persons with limb impairment as a result of a chronic medical condition. A copy of that AOPA/AC letter is attached for your information and review.

In recognition of these pending serious reimbursement threats, **AOPA has hastened the timing of its 2013 AOPA Policy Forum so that it will take place March 12-13 at the L'Enfant Plaza Hotel, so our members will have a chance to visit and discuss these issues with their legislators before action is taken on some or most of these matters.** Please come to the AOPA Policy Forum and bring one of your patients with you. We urge you to support the Policy Forum and to attend—we need you to be there to defend your patients and your reimbursements directly to the persons you vote for to represent you. Go to www.AOPAnet.org and select the Legislative and Regulatory pull down menu and click on Policy Forum. You can also fax or mail the enclosed registration form to AOPA to reserve your place at this all important opportunity to make a difference.

We will continue to keep you informed as these crucial deliberations progress in the coming weeks, and may request your advocacy in ways other than attendance at the annual AOPA Policy Forum. Hang on tight, and get ready—the coming ten weeks promise to be a frightening, rugged ride!

Very truly yours,

Thomas F. Fise, JD
AOPA Executive Director

A letter of action to the Members of Congress from the Amputee Coalition and AOPA:

Specialists in delivering **superior treatments and outcomes** to patients with limb loss and limb impairment.

www.AOPAnet.org

December 7, 2012

Serious Adverse Impact on Amputee Care Would Ensue If Recent Communications from the Center for American Progress Were Adopted, and Competitive Bidding Were Adopted for Acquisition of All Medicare Medical Devices in DMEPOS.

Custom-Fabricated Prosthetics, As Well As Custom-Fabricated and Custom-Fitted Orthotic Bracing Typically Refers to a combination of services for the Medicare Beneficiary which includes both the product and a Long-Standing Clinical Relationship of Patient Care and Clinical Visits/Interactions Between the Medicare Beneficiary Amputee or Limb-Impaired Patient and His/Her Caregiver Where the clinical services needed by the Medicare Beneficiary Amputee or Limb-Impaired Patient.

Dear Member of Congress:

We are writing because we have been very concerned with overly simplistic and under-informed communications which have recently appeared in the name of the Center for America Progress. CAP essentially has argued for universal competitive bidding expansion to encompass every medical device made available to beneficiaries in the Medicare program, and offers the promise that doing so would save the government $38 billion. This is a very tantalizing idea put forward in a delicate time when fiscal cliff/sequestration deliberations could trigger quick attention to a promise of such extensive potential savings. Unfortunately, such universal reliance on competitive bidding would result in devastating interruptions and disorientation of the care of Medicare beneficiary amputees, and of similarly situated beneficiaries with limb impairment from chronic conditions like multiple sclerosis, cerebral palsy, scoliosis, spina bifida and others—patients whose mobility is severely threatened and who rely on ongoing prosthetic and orthotic care to maintain their independence. CAP clearly does not understand that prosthetics for an amputee is more than a simple commodity such as a walker or a cane, it is a medical device that is attached to a person's body and use of the prosthetic device involves a great deal of fitting as well as health care intervention by a provider they trust and who understands their needs. This is what will be lost by treating prosthetics and custom orthotics like a cane or a walker.

Care of these Medicare patients is not accomplished by the mere delivery of a medical device—this is a critically important distinction because prosthetics and orthotics are dramatically different from typical items in the durable medical equipment category. Confusion may be engendered by the fact that, for whatever historical reasons, Medicare payment for orthotics and prosthetics has been made on the basis of the device, rather than on the basis of the number or intensity of patient visits and encounters which are associated with fitting the patient for the device and teaching the patient to properly use the device. That said, the complexity of custom-fabricated prosthetics as well as custom-fabricated and custom-fitted orthotics, coupled with the typical patient's need for regular, ongoing training, adjustment, modification and refinement underscores the huge risk and detriment to existing patient care that would be perpetrated if the recommendations of CAP were followed and these custom medical and mobility-restoring devices were treated in the same way as an off the shelf commodity such as a walker or a wheel chair.

Suppose that health economists recommended that Medicare could exercise dramatic cost containment if the program started issuing patient visit vouchers to beneficiaries, directing them to secure their medical visits at the offices of physicians who, while unknown to the beneficiaries, had enrolled in a program committing to the lowest 'per visit' cost to Medicare? Congress would almost certainly reject such a concept as inimical to what the average citizen conceives health care encounters with their physician to consist of, and we would agree.

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A letter of action to the Members of Congress from the Amputee Coalition and AOPA:

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Medicare has already considered the question of adding prosthetics and custom orthotics to the competitive bidding program and has drawn the appropriate conclusion that they are not a good fit for the program. We agree with this conclusion.

If the concept of universal competitive bidding as touted by CAP were adopted as to prosthetic patients because they would receive the product without appropriate custom fitting, gait training and other clinical services needed to make the device useful to them. We cannot blithely expect that these patients can be re-directed into a program which would have their customized limbs and bracing coming to them in box, directed via a Medicare-sanctioned distribution warehouse operation. Artificial limbs are not diabetic test strips or wheel chairs; they are instead custom made devices tailored, fitted, and modified regularly to the patient's unique anatomical and skin features. Commoditization of prosthetics and orthotics would divorce those patients from maintaining their long-standing clinical patient care relationship and visits with their trusted health care professionals—the specific prosthetists and orthotists who understand and have earned the patients' trust over decades of specialized treatment and care.

We cannot be sure how the blanket approach to competitively bid all medical devices espoused by the CAP might impact other beneficiary-provider relationships. But we know that this would be a terribly destructive idea if applied to Medicare orthotic and prosthetic care, and we therefore strongly urge members of Congress to support the current position of Medicare and reject any such concept of commoditizing orthotic and prosthetic care proposed by the CAP, and in doing so, continue to protect their constituents who are Medicare amputees and limb-impaired patients.

Thank you for your interest and concern for Medicare patients with limb loss and limb impairment, and please let us know if we can provide any further information.

Very truly yours,

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