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HEALTH CARE REFORM – WHAT IS IT AND WHAT IT MEANS TO PMD SUPPLIERS

As President-elect Obama assembles his health care team, Members of Congress have been quick to publicly stake out their positions and are beginning to debate the merits of a comprehensive health care reform bill. President-elect Obama has signaled that, unlike the failed Clinton effort, health care reform provisions will be cobbled together through the Congressional hearings process. Not only will this ensure a wide range of opinions and public debate, it will also allow health care stakeholders greater opportunity to influence the process.

Questions remain as to legislative strategy.



Congressional Democrats have made it clear that they would like to extend the [State Children's Health Insurance Program](#) (SCHIP) and they must confront another physician fix or pass a major overhaul of the Medicare physician reimbursement system in the next year. Both of these priorities will cost billions. Add to this mix the belief of many that the next Congress represents that last best chance for comprehensive health care reform, there might be a “swing for the fences” approach that will seek to expand SCHIP, reform Medicare and extend health coverage to the uninsured in one piece of legislation.

Another factor aiding the real possibility of health care reform will be the possible repeal of “pay-go” rules which would require any budget outlays to be offset by a revenue raiser. Congressional leaders are



framing the health care issue as “an investment,”

Congressional speak for a Keynesian approach and increased public spending. These signals, coupled with

President-elect Obama’s statements that he will not be too concerned with the federal deficit, at least in the short-term, ensure that budget constraints should not be a major impediment to reform.

What does the prospect of health care reform mean for power mobility device (PMD) suppliers? Certainly, any expansion in health coverage will translate into increased access and an up tick in PMD utilization. Reimbursement for PMDs, however, will continue to be a target for cost-cutting as policy makers continue to compare Medicare pricing with PMD prices over the internet.

The following are some highlights of just two of the major health care reform plans currently being discussed on Capitol Hill:

The Baucus Plan

The Baucus Health Plan, being proffered by Sen. Max Baucus (D-MT) chair of the Senate Finance Committee, released a health reform “white paper” entitled, [A Call to Action: Health Reform 2009](#) that is similar in many aspects to the Obama health proposal. Highlights of the Baucus plan include:

- Basing the system on existing private and public health plans— employer-provided coverage, Medicare, Medicaid, and SCHIP.
- Regarding durable medical equipment (DME) – Baucus calls for implementation of competitive bidding as a way to control pricing and decrease fraud and abuse in the Medicare DME benefit.
- Insurance exchanges - Creating a system of one or more Insurance Exchanges for individuals and small business to buy their coverage from complete with a management board to run it— very similar to the Massachusetts Connector and the Connector Board.
- Premium subsidies - The Insurance Exchange Board would determine a schedule of coverage affordability based on available health plans, their costs, and income levels. A tax credit would be available to subsidize those deemed not to be able to afford part or all of the cost.
- Medicare buy-in - Before the Insurance Exchange is up and running and its plans available to consumers, Baucus would allow those age 55-64 to buy-into Medicare.
- Insurance regulation - Insurers could offer health plans through the exchange but would have to comply with benefit and plan option requirements and would be subject to guarantee issue requirements. The health plans could rate around restricted age, sex, and lifestyle issues.
- A government-run plan for the under-65 market - After the Insurance Exchange is running the Baucus approach would create a government-run option for consumers to choose.
- Traditional insurance distribution - Insurers could also market outside the exchange using the traditional direct and intermediary distribution systems.
- Medicaid expansion - Medicaid would be expanded to cover all of those below 100% of poverty who were uninsured.
- SCHIP expansion - SCHIP would be expanded to cover all of those below 250% of poverty who were uninsured.
- An employer mandate - All but the smallest employers would be required to offer and pay for coverage or pay into a government pool—“pay or play.”
- Medical malpractice reform – The Baucus plan explores a number of medical malpractice reform ideas around the theme of no fault health courts but makes no specific proposal.
- Physician payment reform – Baucus’ plan calls for better payments for primary care, reforming the Sustainable

Growth Rate formula, and pay-for-performance and quality.

While Baucus Health Plan is that he offers no cost estimates or mentions how he would pay for, it is estimated that the Obama health plan, which is similar in many respects, would cost at least \$100 billion a year.

The Daschle Plan

President-elect Obama has signaled that former [Senate Majority Leader Tom Daschle](#) (D-SD) will be his designee to head up the Department of Health and Human



Services. Last summer, Daschle authored a book dealing with the American health care system. In his book, *Critical: What We Can Do About the Health-Care Crisis*, Daschle sets out the following ideas

for reforming health care:

- Daschle says Medicare should pay more for care that leads to good outcomes, and should stop paying for unnecessary or harmful treatments. Like Obama, he says Americans who want to keep their employer-based insurance should be allowed to do so, but people should also be able to buy insurance from the pool that covers federal employees, or from a new pool based on a similar model.
- Daschle also argues that all Americans should be required to buy health insurance — a key difference from Obama, who argues that only children should be required to have health insurance.
- Daschle's plan calls for creating a Federal Health Board, modeled on

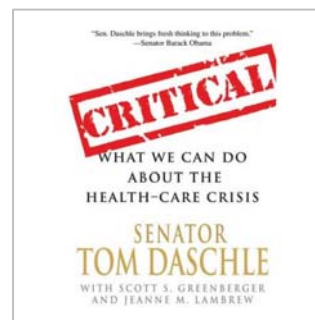
the Federal Reserve Board that will be “largely insulated from the politics” and would have power over federal health-care programs, including Medicare and Medicaid. It would also set the terms for private insurers who wanted to participate in the federal employees’ insurance pool.

- The Board would also assess the effectiveness and costs of various treatments.
- Daschle stops short of saying the U.S. should have a U.K.-style, hard-and-fast rule on cost-effectiveness. He does write, however, that the U.S. “won’t be able to make a significant dent in health-care spending without getting into the nitty-gritty of which treatments are the most clinically valuable and cost effective.”

Conclusion

PMD suppliers are well positioned to be successful under any health care reform effort. It is clear that any successful health reform plan will rely on preventive care, measured outcomes and increased efficiencies.

PMD suppliers and advocates must demonstrate to legislators that access to PMDs saves federal health care programs resources by keeping beneficiaries out of costly institutional settings and safer in their environment. A trend toward efficiencies may also help Medicare adopt a more consistent documentation standard for PMDs.



The PMC will continue to monitor the progress of the health care as it commences in the 111th Congress and will remain the voice of PMD suppliers as the debate begins.

THE RACs ARE COMING – THE RACs ARE COMING

*Audit Program Would Offer Additional
Level of Scrutiny to Medicare Claims*

Power mobility device (PMD) suppliers should expect an additional level of scrutiny in the New Year as the [Recovery Audit Contractors](#) (RAC) program starts to ramp-up its oversight of claims submitted by all health care providers, including durable medical equipment claims. In October, the CMS and Medicaid Services (CMS) announced the contractors for the initial roll-out of the RAC Program. A subsequent protest, however, has “suspended” current RAC activities. The



Governmental Accountability Office (GAO) has 100 days to make a determination on the protest, meaning RAC activities will most likely not resume until mid-February at the earliest. Still suppliers should begin to associate themselves with the RAC program and what RAC audits entail.

[The Tax Relief and Health Care Act of 2006](#) mandated that CMS implement a national RAC program by January 1, 2010. Despite the protest, CMS is continuing to implement other pieces of the RAC

program, conduct provider outreach and stated in a recent special open door forum that they expect to meet the RAC implementation 2010 deadline.

The national RAC program is the outgrowth of a demonstration project that used RACs to identify Medicare overpayments and underpayments in California, Florida, New York,



Massachusetts, South Carolina and Arizona. The

demonstration resulted in over \$900 million in overpayments being returned to Medicare between 2005 and 2008 and nearly \$38 million in underpayments returned to health care providers.

The RAC program will provide two types of review; an automatic review and a more complex audit. Automatic reviews under RACs will employ data mining techniques; examine coding issues and other recommendations provided by GAO and [Office of the Inspector General](#) (OIG). These reviews will require no medical documentation from providers and, in most cases, providers will not even know they under review unless they receive a demand letter from the RAC.

Complex reviews will require provider participation, including providing supporting documentation within 45 days of receiving notification of the RAC. Providers, with the exception of in-hospital stay claims, will not be reimbursed for providing documentation to the RACs. RAC auditors also have the authority to look back at claims for three years. Initially, however, RACs will only look back to claims dated October, 2007 and

will increase the length by a month for each month of implementation until the three-year threshold is met.

Providers who receive demand letters from RACs have three options: 1) allow the recoupment and pay by check; 2) file an appeal; or 3) file for an extended payment plan. If a provider disagrees with a determination, the RACs will offer a “discussion period” with RAC representatives where suppliers can provide additional information to support your claim.

Critics of the RAC program are concerned of the “bounty-hunter” aspects of the audits and that the audits are another way for CMS to “nit-pick” claims. CMS representatives tried to alleviate concerns stating that they plan to evaluate RACs based on customer service, not on collections. Nor do RACs have any quotas “per se.”

CMS awarded the first round of RAC contracts to the following vendors. The new RACs are:

- **Diversified Collection Services, Inc.** of Livermore, California, in Region A, initially working in Maine, New Hampshire, Vermont, New York, Massachusetts, and Rhode Island;
- **CGI Technologies and Solutions, Inc.** of Fairfax, Virginia, in Region B, initially working in Michigan, Indiana and Minnesota;
- **Connolly Consulting Associates, Inc.** of Wilton, Connecticut, in

Region C, initially working in South Carolina, Florida, Colorado and New Mexico;

- **Health Data Insights, Inc.** of Las Vegas, Nevada, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

Additional states will be added to each RAC region in 2009. A map of the RAC Regions and the implementation timeline can be found at:

<http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

The PMC has a myriad concerns with the RAC program, not the least of which is the “bounty-hunter” aspect of the contractor payment and the ability for auditors to reach back to examine previously closed claims. Some in Congress, like [Representative Lois Capps](#) (D-CA), pictured below, have voiced similar concerns and promised to work with the Government Accountability Office to ensure fairness, transparency and greater oversight of RAC audit activities. As Rep.



Capps noted, “I will continue my efforts to monitor this program to ensure that when it is finally implemented it contains important safeguards to protect healthcare providers and their patients. As part of that effort, I will

be...requesting a review of the RAC program as the national rollout begins from the non-partisan Government Accountability Office. This report is necessary to ensure proper oversight of the program and reporting back to Congress.”

Heard on the Hill.....

*T*he Centers for Medicare and Medicaid Services (CMS) has submitted the new regulations on competitive bidding for clearance with the Office of Management and Budget. It is not known when the new rules will be made public but it is rumored that the regulation will be released as an interim final rule which will allow for a public note



and comment period.....Some health care insiders have indicated that Health and Human Services Secretary-designee Tom Daschle may name [Judy Feder](#) (pictured left) to a major post in the agency. **Feder**, a health policy professor at Georgetown University, recently lost an election for Congress to represent Northern Virginia. Other names thought to be under consideration for CMS administrator include: Avalere Health President **Dan Mendelson**; **Robert Berenson**, a scholar at the Urban Institute; and **Ken Thorpe**, a professor at Emory University.



BEST WISHES FOR THIS HOLIDAY SEASON

*T*he PMC wishes you and yours the best this Holiday Season and a Happy, Healthy and Prosperous New Years. The coming year promises to bring many changes and challenges to our health care system and the PMC looks forward to representing the interest of power mobility device suppliers, manufacturers and beneficiaries as Congress and policymakers debate health care reform.

