For Home TPN and Tube Feeding Patients

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On July 1 and October 1, 2013, some big changes occurred to our government and non-government insurance systems as a result of healthcare reform. Because of these and other reform-related changes, we present you with this issue of Celebrate Life. It helps explain some of the bigger healthcare reform concepts that affect our TPN and tube feeding consumers. I am so pleased to serve as Guest Editor of this very important issue.

We start with an article based on a talk I gave that covers the basics of what every consumer should know about healthcare reform. The article reviews the key provisions of the Affordable Care Act (ACA) of 2010 — known as healthcare reform — and how they affect each of us. We start with changes that have already come to pass. We then go into the changes that are in process and yet to come, which include Accountable Care Organizations and the healthcare mandate. We hope this article gives you a useful foundation of knowledge about healthcare reform.

We move on to an article by Karen Hamilton about Medicare, another topic that can be confusing. Karen does a great job of explaining the details of how Medicare coverage and reimbursement guidelines affect TPN and tube feeding consumers. If you’ve ever wondered about the differences between Parts A, B, C, and D, or about the criteria required to qualify for Medicare, this article will help clear things up for you.

Next, we hear from Melinda Parker about Medicare’s new Competitive Bidding program. This program covers certain respiratory and durable medical equipment, nutrients, and supplies. It is a subject that is well-known to many of our tube feeding consumers. Competitive Bidding is a Medicare Part B program that essentially contracts with a group of providers of supplies and services in over 100 areas of the country. The goal of the program is to save money and improve quality of care. Coram is very pleased to have been chosen as a “contract provider” for enteral nutrients and pumps in all 109 “competitive bidding areas” across the country. We’ve also been chosen as a provider of infusion pumps in the bid areas affected by the latest round of bidding, which will take effect in January 2014. As a result of Competitive Bidding, we have welcomed numerous patients onto Coram’s service. We look forward to welcoming many more.

This brings us to our patient story about Jim Mszanski. Jim is a tube feeding consumer who recently came on service with Coram as a result of Medicare’s Competitive Bidding program. Jim shares the story of how his tube feeding provider lost the competitive bid, and how he chose Coram to replace them. He also explains how he had to choose a new provider for his diabetes supplies. While this may sound like a complicated process, Jim is very pleased with his new providers and how things have worked out for him.

All of the topics addressed in this magazine can be hard to understand, and I hope this issue of Celebrate Life is helpful and informative for you. All of us at Coram wish you a very happy and healthy end of 2013!

Lisa Getson
Executive Vice President, Government Relations and Corporate Compliance,
Apria Healthcare Group / Coram LLC
HEALTHCARE REFORM: WHAT CONSUMERS NEED TO KNOW

1. ESTABLISHMENT OF A MANDATE FOR MOST LEGAL U.S. RESIDENTS TO OBTAIN HEALTH INSURANCE
2. CREATION OF INSURANCE EXCHANGES FOR INDIVIDUALS AND FAMILIES
3. EXPANSION OF MEDICAID ELIGIBILITY

PASSED INTO LAW IN 2010
EXPANDED INSURANCE COVERAGE
COVERED PRE-EXISTING CONDITIONS

AFFORDABLE CARE ACT, A.K.A. ...

REDUCTION OF MEDICARE PAYMENT RATES FOR MOST COVERED SERVICES
ADDITION OF SOME INCREMENTAL TAXES ON INDIVIDUALS AND FAMILIES
ENDORSEMENT OF MODELS SUCH AS THE ACCOUNTABLE CARE ORGANIZATION* AND PAYMENT BUNDLING*
THE ACA IS A MAJOR OVERHAUL OF THE HEALTHCARE SYSTEM

ADAPTED FROM AN AUDIO PRESENTATION GIVEN IN SEPTEMBER 2012, WHICH CAN BE FOUND ONLINE AT: WENOURISH.COM/EVENTS/EVENTS_ARCHIVE.ASPX
By Lisa M. Getson, Executive Vice President, Government Relations and Corporate Compliance, Apria Healthcare Group / Coram LLC

It’s hard to believe that the Affordable Care Act (ACA) of 2010 — known as healthcare reform — was passed into law over three years ago. This complex law, which is thousands of pages long, is a major overhaul of the healthcare system and will be implemented in stages over a number of years.

**Highlights of the ACA Include:**

- Establishment of a mandate for most legal U.S. residents to obtain health insurance.
- Creation of insurance exchanges for individuals and families to receive federal subsidies* to reduce the cost of purchasing that health insurance.
- Expansion of Medicaid eligibility and the addition of thousands of additional individuals to state Medicaid rolls.
- Reduction of Medicare payment rates for most covered services.
- Addition of some incremental taxes on individuals and families with relatively high incomes, and changes to Medicare and Medicaid programs at various aspects of the Federal Tax Code.
- Endorsement of models such as the Accountable Care Organization* and payment bundling.*

This article provides an overview of the main provisions of the ACA and outlines how they will impact U.S. consumers and patients. The ACA will be phased in over time, so we’ll start with provisions that have already been implemented, and then move on to future aspects of the legislation.

**Provisions Already Implemented**

When the legislation was first passed, some of the provisions seemed so far off. But actually, several of the provisions have been implemented since 2010:

- **The extension of dependent coverage to age 26.** Young adults can stay on their parents’ health insurance until they turn 26.
- **Medical loss ratio requirements for health plans.** The law prescribes the amount of money that health plans can spend on administration (such as salaries and marketing) versus on direct patient care. Large group insurers must spend at least 85% of premium dollars on claims and activities to improve healthcare quality. Individual and small group insurers must spend at least 80% of premium dollars on these activities.
- **Pre-existing condition protections.** Protections were implemented that forbid insurers from not covering people who have pre-existing conditions and/or dropping them when they become sick. This provision includes prohibiting insurers from excluding coverage of pre-existing conditions in children for plan years beginning after September 2010.

*Please see the glossary on page 8.*
• A $250 “Donut Hole” rebate for Medicare Part D. This rebate helps to close the Medicare Part D Donut Hole. (This is the portion of a Medicare prescription drug plan in which the beneficiary is 100% responsible for their medication costs.) A one-time, tax-free $250 rebate check was sent to each Medicare Part D plan member who reached the Donut Hole.

**Coram’s Advocacy for Medicare Reform**

Coram is working with the CMS Innovation Center to encourage them to study the value of home infusion therapy, such as home parenteral nutrition, intravenous antibiotics, pain management, and other therapies. Traditional Medicare has a loophole that prevents thousands of patients from benefitting from home infusion, despite its proven cost-effectiveness, safety, and quality of care. So, we’re working with policymakers from Congress and the Center to urge them to complete a study on the value of home infusion in the Medicare population.

**Coram’s Reduction of Hospital Readmissions**

Coram plays an important role in preventing readmissions as well. We provide home nutrition and infusion therapy that is closely monitored by experienced clinicians to help ensure a positive response to prescribed therapy. Our clinicians communicate with the ordering physician to provide timely feedback about patient progress and therapy tolerance. We also monitor all patients for readmission within 30 days of start of care, and after 30 days on service, and have consistently demonstrated low readmission rates. (Coram’s Unplanned Hospitalization Rate: 2.6%)
The Competitive Bidding Program helps ensure that only accredited, financially sound, quality providers are serving Medicare beneficiaries for the relevant products. While patients may find fewer qualified providers from which to choose, their out-of-pocket expenses should be lower under the program.

For more information about Competitive Bidding, please see page 14.

Provisions Still to Come

There are still major changes to come as a result of the healthcare reform legislation. Following are the main components yet to be fully implemented.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are part of the government’s plan to help reduce the costs of healthcare in the U.S. An ACO is a group of doctors and hospitals that share responsibility for providing care to a large group of patients, including Medicare beneficiaries. The first applications to be recognized by CMS as “Pioneer ACOs” were submitted in 2012, and ACOs continue to form across the country. ACO providers are rewarded with a share of any savings that the program achieves. The ACOs must be legal entities, have enough primary care providers in them to serve 5,000 people, and use evidence-based medicine.* They also have to show that they are engaging patients in their own care, helping them understand their own care, and coordinating care across the health care continuum.

Annual Limits and Lifetime Caps

The ACA is very specific about annual limits. This is likely in response to past stories about various health plans dropping patients if they or their family member became ill, or if they exceeded certain spending limits. As highlighted previously, the ACA dictated that the annual limit for 2012 could be no lower than $1.25 million. For 2013, it can be no lower than $2 million, and for 2014, no annual limits may be permitted. And for plan years beginning after September 23, 2010, health plans cannot impose a lifetime limit on benefits.

Coverage for Pre-existing Conditions

Healthcare reform will provide coverage for people who could not previously get insurance due to their medical conditions. High-risk pools will be created for people who have been uninsured for at least six months and have been refused insurance coverage. Through these pools, insurers offer coverage for qualified high-risk patients. The coverage will be offered until either 2014, or depletion of the $5 billion in federal money that was made available by the healthcare reform law. Beginning in 2014, insurers will be required to issue policies to people with pre-existing conditions and they will not be able to charge them higher premiums.

Essential Health Benefits Package

One aspect of healthcare reform that impacts the home infusion industry is that the legislation allows the Secretary of Health and Human Services to develop an “essential health benefits package.” This means that the Secretary can determine what must be included in every insurance exchange’s basic health benefit plan. We are not aware of any explicit coverage for home infusion, but if the Secretary finds that something is very cost-effective, such as home infusion, it is likely that they will include that in their final benefit package.

Cuts to Medicare

In order to pay for healthcare reform and preserve the Medicare Trust Fund for future generations, the ACA legislation included $524 billion worth of Medicare cuts over 10 years. For example, for a Medicare Advantage plan, those cuts are approximately $200 billion over 10 years. The cuts mostly affect the amount that Medicare pays to plans to take care of managed Medicare patients. While there are safeguards in place to prevent the Medicare Advantage plans from reducing benefits to patients, there are a significant number of cuts.

*Please see the glossary on page 8.
being imposed on those health plans. Whether those cuts will impact the patients or the beneficiaries downstream remains an open question. Other segments that will experience payment cuts authorized by the ACA include acute care hospitals, long-term care hospitals, home health agencies, and durable medical equipment providers.

Healthcare Mandate
Another way that the costs of healthcare reform will be managed is with a coverage mandate. The mandate was to be implemented in 2014 but was recently delayed until 2015. This “individual mandate” states that most Americans will be legally required to carry health insurance. For instance, in 2014, many adults were to be penalized $95 for not buying coverage. That amount will rise to $695 in a few years. Businesses have requirements as well, but that provision was also delayed until 2015. If a business with 50 or more workers chooses not to provide coverage, it must pay a tax penalty of $2,000 per worker, a number that will increase in future years.

In June 2012, the Supreme Court upheld that the healthcare reform law was constitutional, and described the individual mandate as a tax. Therefore, the agency that is charged with enforcing this requirement is the Internal Revenue Service (IRS). Through the annual payment of taxes, the IRS can make sure that people are buying health insurance or paying the tax penalty.

Costs and Benefits of Healthcare Reform
Some in the healthcare industry believe that premiums will rise as a result of health reform. This projected increase would result from the expansion of health care coverage, the number of increased Medicaid enrollees, the coverage of dependents to age 26, and other provisions. Another cost of the legislation is the deep Medicare benefit and payment cuts, which may have a “trickledown” effect, certainly on the providers and the suppliers caring for patients.

This impact on premiums will vary by market and is offset at least in part for many individuals and small businesses by the subsidies that the Federal government will begin paying in 2014. While there are significant costs associated with healthcare reform, many of the law’s provisions are very positive, and benefit the social welfare of the country and all involved in the healthcare system.

Conclusion
The healthcare reform legislation is very complex, and we will know a lot more about the results of its provisions over the next few years. As a company with a reputation for being flexible and adapting to the changing environment, we are prepared and ready for the reforms and the increased reporting and regulations that the law brings. We believe that the healthcare reform law provides tremendous opportunities for savings through the use of home care. We are optimistic about some of the law’s provisions that are designed to improve the overall healthcare system in our country.

See also: Healthcare Reform Resources on page 22.

GLOSSARY

- **Accountable Care Organization (ACO):** A group of doctors and hospitals that share responsibility for providing care to a group of patients, which may include Medicare beneficiaries. A “Pioneer ACO” is designed for healthcare organizations and providers that are already experienced in coordinating care for patients across care settings. The 23 Pioneer ACOs were the first ACOs created. They took on greater financial risk to pocket more of the expected savings.
- **Annual limits:** Yearly limits on the amount of services that insurance companies will cover.
- **Bundling:** A payment model that pays care providers one set fee when providing multiple services in a single episode of care. This is instead of paying for each service individually. The goal of bundling payments is to help improve quality and lower costs.
- **Evidence-based medicine:** The practice of medicine in which a doctor diagnoses and treats a patient based on the best available current research or published best practices, as well as their clinical expertise and the needs and preferences of the patient.
- **Individual mandate:** A provision of the ACA that requires most Americans to have health insurance. Individuals who do not carry health insurance will have to pay a penalty starting in 2015.
- **Subsidies:** Provisions offered by the ACA to lower premiums and cost-sharing obligations (such as deductibles and copayments) for people with low and modest incomes. The ACA also provides subsidies that help lower premium cost growth for small businesses.
Understanding Your Options

By Karen Hamilton, MS, RD, LD, CNSC, Director, Nutrition Services and Programs

Medicare:

It can take time, education, and many questions answered before a consumer feels comfortable managing their home parenteral or enteral nutrition (HPEN) therapy. So, it would be no surprise that a consumer would need these same things before feeling that they have found the best insurance solution for their needs.

If you will be turning 65 years old in the near future, or if you have been receiving Social Security disability benefits for nearly 24 months, you will soon become eligible for Medicare coverage. This article provides information that can help you determine how best to obtain and keep Medicare coverage for your home nutrition support therapy.

What Is Medicare and Who Is Eligible for Coverage?

Medicare is one of the health insurance programs provided by the U.S. government. It provides health coverage to citizens who are 65 years old or older. It also provides coverage to citizens younger than 65 who have received Social Security disability benefits for 24 months, or who suffer from end-stage kidney disease. To qualify for Medicare, you or your spouse must have worked at least 10 years in a job that contributed to the Medicare trust fund. Also, disabled widows and widowers under age 65, as well as disabled children, may be eligible for Medicare, usually after a 24-month qualifying period.

Most people do not need to apply for Medicare benefits because they will be automatically enrolled at age 65. Those who are not automatically eligible are required to apply for Medicare coverage, and sometimes must meet specific requirements.
For HPEN consumers, having Medicare benefits does not automatically guarantee coverage for home nutrition therapy. For total parenteral nutrition (TPN) consumers to qualify for coverage, they must have a medical condition that meets one of seven criteria outlined later in this article. For consumers who receive enteral nutrition (EN), or tube feeding, their medical condition must meet one of two criteria to qualify for coverage (also described later in this article). Their doctor or hospital must provide the HPEN provider with extensive documentation or medical chart notes that support the prescription for the therapy. A faxed or verbal order, desktop prescription, or other informal referral is not sufficient to obtain Medicare coverage. Additional face-to-face visits with a doctor or healthcare practitioner and/or further testing may also be required. Once a consumer is qualified, Medicare will pay for 80% of allowable charges. The remaining 20% can be covered by a supplemental* or secondary insurance,* or you may need to pay this balance yourself.

**Which Medicare “Part” Is Right for Me?**

*Traditional Medicare has two parts:*

- **Part A (Hospital Insurance)** covers most medically necessary care received in a hospital or skilled nursing facility, or through home health or hospice care. Part A is free if you have worked and paid Social Security taxes for at least 40 calendar quarters (10 years). If you have worked and paid taxes for less time, you will pay a monthly premium. For individuals who receive EN or TPN in the hospital, their nutrition therapy is covered fully under their Part A benefit, much the same as their meals would be.

- **Part B (Medical Insurance)** covers most medically necessary doctors’ services, preventive care, durable medical equipment, and hospital outpatient services. It also covers most laboratory tests, x-rays, mental health care, and some home health and ambulance services. Under the durable medical equipment provision, *both* home TPN and EN can be covered if medical criteria are met and detailed documentation is provided by the prescriber. Outlined on pages 11 and 12 are the medical criteria that must be met to qualify for coverage. For Part B coverage, you will pay a monthly premium that is deducted from your Social Security payments. Any copays not covered by supplemental insurance you will need to pay out-of-pocket. Also, Medicare’s new Competitive Bidding program requires beneficiaries to use only contract suppliers who have been approved by the government. This applies to tube feeding and infusion pump providers.

**Medicare Part D (Prescription Drug Insurance)**

Medicare Part D is the part of Medicare that provides outpatient prescription drug coverage. Part D is provided only through private insurance companies that have contracts with the government. It is never provided directly by the government (like traditional Medicare is). Part D is optional for most people. However, if an individual has Medicare and Medicaid, Part D is automatically provided. Whether you should take it depends on your current drug coverage and needs.

If you want Part D coverage, you must choose a Part D plan that works with your Medicare health benefits. If you have traditional Medicare, selecting a stand-alone Part D plan is necessary for drug coverage. Enteral therapy is not covered under Part D. For home parenteral nutrition (HPN), if a consumer does not medically qualify under Part B coverage, the lipid and amino acid portion of the HPN formula can be billed to Part D. This option is rarely used, as it provides incomplete coverage.

**Medicare Part C**

Medicare Part C is not a separate benefit. Part C is the part of Medicare policy that allows private health insurance companies to provide Medicare benefits. These Medicare private health plans,
such as HMOs and PPOs, are sometimes known as Medicare Advantage plans. If you prefer, you can obtain your Medicare coverage through a Medicare private health plan instead of a traditional Medicare plan. For TPN and tube feeding consumers who wish to choose Part C, it is important to verify that the private health plan covers HPEN services. It is also important to ask about the plan’s requirements for coverage for these therapies, as these requirements may differ between plans.

**What Additional Medical Criteria Must I Meet?**

**Home Enteral Nutrition (Tube Feeding) Criteria**

Medicare will only consider covering your home EN if the length of need is expected to be greater than 90 days. Once this requirement is met, you must have a medical condition that falls into one of two categories:

- **Permanent non-function or disease of the structures that normally permit food to reach the small bowel.** Put plainly, a person can no longer take an oral diet to support their nutrition needs. This may be a result of a swallowing disorder after stroke or surgery for head and neck cancer. Or it may be due to a stomach or intestinal blockage that does not allow food to pass.

- **A disease of the small bowel that impairs digestion and absorption of an oral diet.** Simply stated, the enteral consumer has a disease that affects nutrient absorption. Examples of these diseases include pancreatitis and Crohn’s disease.

An objective test to prove that the medical criteria are met is required. For example, if a consumer needs enteral feeding for six months due to a stroke, a swallow study would be needed. This would demonstrate that the consumer cannot swallow and thus needs EN. The doctor would also need to document a face-to-face visit with the patient, and specify how long the therapy would be needed. In addition, the doctor would need to write notes in his/her records to explain that the consumer requires EN in order to maintain weight and strength. The fact that the tube feeding is the consumer’s major source of nutrition would also need to be documented. All of this documentation must be placed in the consumer’s medical record maintained by the doctor or treatment facility. Medicare will not accept documentation that is created by the HPEN provider.

Finally, if a specialty formula is prescribed, there must be documentation. This must show that a standard formula was tried and was not tolerated. Also, if a pump is needed to administer the formula, further documentation is needed.

If there are changes in the enteral formula, calorie requirements, method of administration, or quantity of supplies, documentation is again required, in writing from the doctor. This must be placed in the medical record. Also, a copy must be supplied to the company providing the EN.

*Please see glossary on page 12.
Home Parenteral Nutrition Criteria

Similar to EN, Medicare will only consider covering your HPN if the length of need is expected to be greater than 90 days. Once this requirement is satisfied, you must have a medical condition that falls into one of seven possible categories (1–4 and 1–3 below). With these conditions, the small bowel cannot process nutrients adequately.

- **A condition involving the small intestine and/or its exocrine glands** that impairs absorption.
  1. **Criteria A**: The consumer has short bowel syndrome (SBS) with an objective test documenting less than five feet of small bowel remaining.
  2. **Criteria B**: The consumer has SBS with high output, resulting in dehydration and electrolyte imbalance.
  3. **Criteria C**: The consumer has a disease that requires prolonged bowel rest. The consumer cannot take anything by mouth and has severe pancreatitis, Crohn’s disease, or an enterocutaneous fistula.*
  4. **Criteria E**: The consumer is malnourished and has severe fat malabsorption.

**OR**

- **A motility disorder that impairs the ability of nutrients to be transported through the gastrointestinal tract.**
  1. **Criteria D**: The consumer has a complete small bowel obstruction.
  2. **Criteria F**: The consumer is malnourished and has a motility disorder of the stomach or small bowel.

**OR**

3. **Criteria G/H**: This criteria is used for consumers who do not meet one of the other criteria (A-F). This means that the consumer is malnourished and has a disease that has not responded to medical and nutrition management. Additionally, the person is malnourished and has tried EN but cannot tolerate it. An example would be a person who has a partial small bowel obstruction rather than a complete bowel obstruction, and has tried a modified oral diet and EN but still cannot support their nutritional needs.

Finally, if calories, protein, dextrose, or lipids are provided in the TPN outside of the Medicare-outlined criteria, there must be documentation of clinical need.

If the number of days of TPN infused is less than seven per week, documentation is again required to be provided by the doctor. It must be placed in the medical record, and a copy must be supplied to the company that is providing the TPN.

**What If My Medicare Part B Coverage Doesn’t Cover My EN or TPN?**

If you need EN or TPN for less than 90 days, or do not medically qualify under Part B, the home nutrition therapy provider may be able to bill Medicare to obtain a denial. This would allow the provider to bill your commercial or state secondary insurance instead.

However, if you have a supplemental insurance plan, when Medicare provides the denial, the supplemental insurance will not cover any portion of the therapy.

In cases when nutrition therapy is needed for weeks or a few months, you may transition from the hospital to an extended care facility. There, you can have continued nutrition support therapy coverage under your Part A benefit until you are discharged.

When an individual does not meet the medical criteria and has no secondary commercial insurance, their doctor may do further testing to demonstrate the need for therapy. Depending on the underlying condition, a doctor may schedule the patient for
an x-ray, CT scan, swallowing study, malabsorption test, motility study, or other test. In some cases, a trial of EN must be attempted in order to show EN intolerance and the need for TPN. Then, Medicare criteria can be satisfied and coverage gained.

**What If I Didn't Qualify for Medicare Coverage At First, But That Changed?**

For example, you may not have qualified for Medicare coverage when you were first discharged home because your doctors thought you needed less than 90 days' worth of therapy. In some cases, your provider can resubmit your qualification information to Medicare. This is true if you have received your nutrition therapy for more than 90 days and you meet one of the seven medical criteria definitions. If Medicare then approves your care, you will gain coverage for your therapy from the new date of documentation submission. The remaining 20% that is not covered by Medicare will then be billed to your secondary or supplemental insurance.

**What Else Do I Need to Consider?**

To be able to use Medicare as your insurer, and for your doctor to accept your Medicare coverage, you must both apply for Medicare. As you consider applying, be sure to ask your doctor if he or she has registered with Medicare so that your doctor can continue to treat you. Also ask if your doctor accepts Medicare “assignment.” This means that your doctor accepts the rates that Medicare is willing to reimburse him or her. If not, you may be responsible for additional charges.

If you are currently an EN or TPN consumer and will be eligible for Medicare benefits soon, let your Coram branch team know several months in advance. This will help them to assist you and your doctor in gathering the required documentation to qualify you for Medicare.

**How Do I Apply for Medicare?**

A consumer who is not automatically enrolled into Medicare when they turn age 65 can set up an appointment to apply for Medicare by calling 800.772.1213. An appointment to apply for Medicare is a free service and will be scheduled at a Social Security office convenient to you.

When you go to your appointment, bring your birth certificate, driver’s license, proof of any other insurance you may have, and your Social Security card. If you are eligible due to disability, be prepared to provide names of doctors, hospitals, and clinics that have managed your care.

**What If I Have Additional Questions?**

If you still have questions about Medicare after reading this article, feel free to email Coram’s Nourish team at NutritionServices@coramhc.com. They will be happy to assist you.

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**Glossary**

- **Secondary insurance**: As the term implies, this is insurance coverage that is available in addition to any primary policy that an insured person may carry. It is often used to supplement existing policies or to cover any gaps in insurance coverage. It may also be present when two spouses have coverage through different employers.

- **Enterocutaneous fistula**: A hole in the intestine that leaks intestinal contents outside of the body.

- **Exocrine glands**: Glands that produce secretions that move to the surface of an organ. These secretions may travel via ducts.

- **Supplemental insurance**: An optional insurance policy that can be purchased in addition to a primary insurance plan. For Medicare patients, supplemental insurance typically covers only the 20% balance left after Medicare covers the first 80%.
What Is Competitive Bidding?

How Does Medicare Select a Contract Supplier?

Where Are the Competitive Bidding Areas?

How Do You Choose a Contract Provider?

What Should You Expect from Your Contract Provider?

By Melinda Parker, MS, RD, CNSC, National Clinical Director, Nutrition
If your primary insurance is Original Medicare and you are a tube feeding consumer, chances are you have heard the term “Competitive Bidding.” But what exactly is Competitive Bidding? And if you live in an area affected by Medicare’s Part B Competitive Bidding program, what do you need to know to ensure that you are getting the enteral nutrients, supplies, and equipment you need? Just as important, how do you make sure that Medicare will continue to pay for your therapy?

What Is Competitive Bidding?
Competitive Bidding is a program of The Centers for Medicare and Medicaid Services (CMS). CMS is the federal body that administers Medicare and Medicaid insurance programs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) ordered that a competitive bidding program be created and phased in over several years. This program affects many different product categories of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It affects tube feeding and supplies in 109 markets, as well as infusion pumps and supplies in nine markets. The MMA requires that the Competitive Bidding process replace the old fee payment schedule for those items. This has resulted in lower costs for the bid items, as well as a limit to the list of providers who may supply the bid items.

Simply put, the Competitive Bidding Program is a competition among tube feeding suppliers that operate in certain areas. These areas are known as Competitive Bid Areas (CBAs). In general, CBAs represent the 100 largest metropolitan areas of the U.S. Previously, tube feeding formula and supplies were provided by suppliers that may not have had the kind of quality review process that Medicare now requires. With Competitive Bidding, the suppliers are chosen based mainly on price. But they are also chosen based on quality and the finances of the supplier. The government estimates that over a ten-year period, competitive bidding will save Medicare almost $26 billion, and consumers over $17 billion.*

Of course, you wonder how all of this affects you. It impacts you if Medicare is your primary insurance and you live in a CBA, and your current supplier has not been awarded a Competitive Bidding contract. If these things are true, you must select a tube feeding supplier that is contracted with Medicare in your CBA. This applies whether you are a new tube feeding patient or a longer-term consumer.

How Does Medicare Select a Contract Supplier?
Only contract suppliers in good standing with the government are selected. Contract suppliers must comply with Medicare enrollment rules. They must be licensed and accredited, and meet financial standards within a CBA. In addition, they must be accredited for each bid item by an independent accrediting organization approved by Medicare. This is all good news for the consumer. These standards help translate to better care for the consumer.

In general, only contract suppliers will be able to serve Medicare beneficiaries in the CBAs. The contract term is three years. When that time is up, the competitive bidding process is repeated and suppliers are reviewed again.

There have been three rounds of bidding in the past five years. Round 1 went into effect on January 1, 2011. Round 2 was implemented on July 1, 2013. There is now a total of 109 CBAs. Meanwhile, the government put the Round 1 markets out to bid again. That round of bidding, called the “Round 1 Recompete,” takes effect on January 1, 2014.
Where Are the CBAs?

The CBAs are spread out all over the country. They include major cities and the suburban areas surrounding these cities. CBAs are defined by specific zip codes. The map below shows you where the CBAs are located. As mentioned above, if your permanent residence is within a CBA, you will need to have a contract provider. Also, if you obtain competitive bid items — such as tube feeding formula and supplies — while visiting a CBA, you will need a contract provider for those items. It is very easy to determine if you are in a CBA. Simply go to www.dmecompetitivebid.com and use their interactive map.

Competitive Bidding Areas

Additional Resources

- DMEPOS Competitive Bidding Program: www.dmecompetitivebid.com
- Supplier Locator Tool: www.medicare.gov/SupplierDirectory
- Medicare Website: www.medicare.gov
- Consumer Information: Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.
About Medicare and Tube Feeding

As you have read elsewhere in this edition of Celebrate Life, Medicare covers equipment and supplies for enteral nutrition therapy (tube feeding) under the Medicare Part B Prosthetic Device Benefit. In order for Medicare to pay for these services, tube feeding must be medically necessary. It must also be justified by certain tests and in written documents found in the medical records of the doctor, hospital, or other qualified care provider. If Medicare is your insurance provider and you are a tube feeding consumer, Medicare Part B will likely pay for it. If you transition from one supplier to another due to Competitive Bidding, you may need to be requalified even if you are a long-term consumer.

How Do You Choose a Contract Provider?

If you are already a Coram patient, you are all set — you do not need to choose another provider. However, if you are not a Coram patient and need to find a contract provider, you can do that easily by going to [www.medicare.gov/SupplierDirectory](http://www.medicare.gov/SupplierDirectory). Type in your zip code and click “Go.” The screen that appears will indicate whether you live in a CBA. If you do, look under “Competitive Bid Categories” and click “Enteral Nutrients, Equipment and Supplies.” Next, scroll down and click “Search.” On the next screen, click on the bar that says “Enteral Nutrients, Equipment and Supplies.” A list of suppliers near your zip code will appear.

Your next step is to select several providers from this list. Call these providers and let them know that you would like information about their tube feeding program. Some key questions to ask include:

1. What medical necessity documentation will they need to prove that you qualify for Medicare coverage? (Examples: copies of documentation from face-to-face visits with your doctor, swallow tests, or your medical chart or other consultations.) These items can help prove that you qualify for and need tube feeding. Also, ask if there are any date-sensitive items. (It is important to know that when you transition to a new provider through this process, the provider must re-qualify you for Medicare. So they may ask you for more documentation.)
2. Do they provide 24/7 customer support?
3. Do they have a comprehensive line of tube feeding formulas?
4. How many years of experience do they have providing enteral therapy?
5. Do they have Registered Dietitians to assist with clinical questions?
6. Can they help you when you travel?

Narrow your search to one contract provider. Then, call that provider and give the necessary demographic, contact, and insurance information to process your referral.

What Should You Expect from Your Contract Provider?

After medical necessity has been confirmed, you should expect the contract provider to provide you with the formula your doctor ordered and all related supplies. Also, you should expect them to offer you the same products that they supply to all of their customers. Finally, the contract provider must supply whatever brand is prescribed by your doctor, unless an exception applies. To ensure that contract providers do these things and follow all rules and regulations, Medicare will audit them on an ongoing basis.

Competitive bidding is considered essential to helping Medicare do two things. The first thing is to set new, lower payments for specific goods and services. The second is to select quality providers. The top priority for CMS is to ensure that you, the beneficiary, have access to quality equipment and suppliers at a fair price. Contract suppliers have signed contracts. These contracts help ensure that you receive the formula, supplies and equipment you need, and that you receive high-quality customer service. Being an informed consumer about the competitive bid process will help you to select the right provider for you.

JIM MSZANSKI:

MAKING COMPETITIVE BIDDING WORK

AFFORDABLE CARE ACT

HOME CARE

MEDICARE

FOR HIM

By Valerie Hansen, Contributing Writer
Competitive bidding, part of the Affordable Care Act (healthcare reform), partly determines which companies can provide enteral nutrition to Medicare patients in this country. Here we profile an enteral nutrition (EN) patient who came on service with Coram as a result of the competitive bidding program.

Background

The competitive bidding program impacts 109 competitive bidding areas (CBAs) that overlap nearly all major U.S. cities. Through the part of the program that covers EN, suppliers in each market submit bids for the cost of EN and related supplies. The bidding companies are either awarded or denied status as Medicare-contract suppliers based on the submitted pricing and several other criteria. A key purpose of the competitive bidding program is to lower the cost Medicare pays for durable medical equipment, which includes EN, and supplies. Another is to streamline the number of companies providing these supplies and help limit fraud and abuse in the Medicare program.

The program has multiple phases. The first phase went into effect in January 2011 and impacted nine CBAs. The second phase was launched in July 2013, and affected the remaining 100 CBAs. In January 2014, another phase begins. In all phases, Coram won the EN bids in every CBA, including Massachusetts, where Jim Mszanski recently came on service. (For more information on competitive bidding, see page 14.)

Jim’s Situation

Jim was hit by a drunk driver 25 years ago with such force that the front of the driver’s car was sheared off. Jim’s car plunged over a guardrail into a ravine. Luckily, some truck drivers saw the accident and called the police. Jim sustained a spinal cord injury that not only left him paralyzed, but with a condition called autonomic dysreflexia (AD).*

“There is a nerve that controls blood pressure and all the nerves in the body,” he explains. “That nerve was damaged in the accident. It affects my stomach, my ability to get food down my throat, and my bladder and bowels.”

Jim was able to eat normally, if carefully, until early 2012, when he was diagnosed with gastroparesis,* a result of his diabetes. The condition caused paralysis of 50% of Jim’s stomach.

Jim started EN in March 2012. He has a gastrojejunostomy, or GJ tube.* With the GJ tube, he has one tube going into his stomach to release built-up pressure. Another tube goes into his small intestine to provide liquid nutrition.

“I have what’s called a ‘feed and flush’ pump with two bags,” Jim says. “One holds the nutrition and the other has water for hydration. I go on the equipment between 10:00 pm and midnight, and continue until mid-morning. Over that time, I take in four cans of a specialty formula that aids in blood sugar control, and absorb roughly 1,000 cc’s of water.”

Enteral nutrition and hydration, however, are just the tip of the iceberg for Jim.

More Complications

When Jim, who is on Medicare, entered the maze of determining which companies were going to service his needs, it didn’t just involve his EN and diabetes. He is also on oxygen due to severely reduced lung function (caused by several factors not related to the accident). He uses a CPAP machine* because of sleep apnea (a sleep disorder). And because his AD affects his bladder and bowel function, he has a catheter that drains his bladder and needs frequent changing.

“I knew about Apria [Coram’s parent company] from a friend of mine who works for them,” Jim says. “After I got a letter from my previous company telling me

*Please see glossary on page 21.
they would no longer be serving my tube feeding needs because they were no longer a Medicare provider, I called Coram. They said they won the competitive bid for my area and could supply my tube feedings.”

Then Jim got notification from the company that provided his diabetes supplies that they had lost the competitive bid. They gave him the names of two companies that had won. However, neither was contracted with Massachusetts Health, a Medicaid program that pays for the portion of Jim's care not covered by Medicare. (Medicare only covers 80% of allowed charges for his approved therapies.) So, without a provider contracted with Massachusetts Health, Jim would have had to pay 20% of his healthcare costs out-of-pocket.

“They would no longer be serving my tube feeding needs because they were no longer a Medicare provider, I called Coram. They said they won the competitive bid for my area and could supply my tube feedings.”

Doing His Research
Jim worked with Coram’s Enteral Nutrition Center to get all the paperwork approved for his enteral nutrition, which involved getting new prescriptions from all of his doctors. He did the same thing with the Florida company providing his diabetes and CPAP supplies.

“I did a lot of research about the competitive bidding program,” he says. “The first thing I had to find out was who supplied what to me and who won the contract. I chose Coram for my tube feeding because they had the feed and flush system and had been doing it for many years.

“The ladies at the Enteral Nutrition Center have been great. If I run short of certain items, all I have to do is call them and they take care of it. If I have a question or concerns about my nutrition, I call Elaine [Arthur, Lead Dietitian] and she works things out.”

Living Day-to-Day
With all of his health issues, Jim says there are three things that keep him going:

“First is that I get up in the morning. I live my life. The second is that there must be somebody ‘upstairs’ who loves me because I have died four times, but I’m still here. And the third is that I have a wonderful wife of 47 years who loves me. Celeste is the loveliest woman in the world.”

Jim made a wise decision early in his battle with paralysis and all the complications that come with having AD: Celeste was not going to be his caregiver. She was going to be his wife.
He has personal care attendants who come in to bathe and dress him and take care of other essential needs. He also has in-home nursing care several times a week to make sure his low-profile feeding tube* and urinary catheter* are clear and clean.

“I love my wife and she loves me, and that’s the way I want it. I know people who have become full-time caregivers of a family member, and sometimes when that happens, a fine line is crossed and the marriage can eventually wash out. I have seen that with people who have spinal cord injuries like mine. But it didn’t happen with my marriage. My wife is my rock.”

With all of Jim’s medical issues — paralysis, enteral nutrition, diabetes, sleep apnea, oxygen, and bladder and bowels affected by AD — it’s amazing that he spends no time feeling sorry for himself. He is proactive about getting the medical treatment that he needs to live. And when he talks about his condition, his tone is calm and matter-of-fact.

“I make sure the visiting nurses and my doctors know everything that is going on with me. A lot of people have never heard of AD, so I find myself educating medical professionals frequently,” he says. “But beyond that I just don’t allow myself to dwell on everything. If something happens, it happens.”

It doesn’t seem likely that anything more could happen to Jim than already has. But if it does, you can be sure that Jim and Celeste will face it together, as they have been doing for 47 years.

We at Coram are so pleased to welcome the inspiring patients like Jim who have joined us, and will join us, as a result of the Competitive Bidding program. If you are interested in learning more, our website offers detailed information about competitive bidding at WeNourish.com/Medicare. You can also call us at 877.WeNourish for information about the services and support that Coram can offer you.

**Glossary**

- **Autonomic dysreflexia (AD):** A potentially life-threatening condition that occurs most often in people with spinal cord damage above the T6 spinal cord level. With this condition, pain or discomfort below the level of spinal cord damage causes a rise in blood pressure that the body is unable to stop. The most common causes of AD episodes are loss of bowel and bladder function.

- **CPAP machine:** A device used with a treatment called CPAP (continuous positive airway pressure). CPAP provides mild air pressure to keep the airways of the lungs open. CPAP is used in the treatment of sleep apnea, and also for obstructive airway diseases such as COPD.

- **Gastrojejunal tube (GJ tube):** A device that provides access to both the stomach and the jejunum (the middle part of the small intestine). A tube is inserted through an opening in the abdomen and goes into the stomach. A longer tube continues through the stomach and into the jejunum. A G-J tube is used to vent the stomach for air or drainage, and to provide enteral nutrition into the small intestine.

- **Gastroparesis:** A medical condition that causes partial paralysis of the stomach. Nerve damage in the stomach reduces or prevents emptying of the stomach contents into the small intestine.

- **Low-profile feeding tube:** A small device that rests on the surface of the abdomen. Tubing is connected to the device and to the feeding pump so that enteral nutrition can be provided through it.

- **Urinary catheter:** A tube that is used to drain the contents of the bladder.
The following is a list of resources that can help you make health insurance choices based on the current and upcoming changes from healthcare reform. If you have questions specific to how your benefits cover your Coram services, please contact us at NutritionServices@coramhc.com.

This listing is not an endorsement of these organizations or information they may disseminate. We strongly suggest that you discuss any information you receive from these organizations with a qualified professional before making any changes in your healthcare, insurance coverage, or home care provider.

**HealthCare.gov**
On October 1, 2013, the health insurance marketplace began offering a new way to obtain affordable healthcare coverage. This website provides detailed information that can help consumers determine their plan choices.

www.healthcare.gov

**Centers for Medicare and Medicaid Services**
The website for the Centers for Medicare and Medicaid Services provides an overview of electronic health records (EHRs) and how they can improve patient care. EHRs are a key component of healthcare reform’s plan to reduce healthcare costs.

www.cms.gov/Medicare/E-Health/EHealthRecords

**White House**
The White House website provides a timeline of healthcare reform in action, recent articles on healthcare news, healthcare reform statistics, and patient videos.

www.whitehouse.gov/healthreform

**The Henry J. Kaiser Family Foundation**
The Henry J. Kaiser Family Foundation website provides information on global health policy and healthcare reform. It also provides information on health costs, Medicare, Medicaid, private insurance, and the uninsured.

http://kff.org/health-reform
Great Escapes™ Can Help!

If you have holiday travel plans, be sure to let your Nourish Nutrition Support Team know. They’ll help you plan a seamless trip with your TPN therapy through our Great Escapes Travel Program. They’ll also provide you with Cory, our TPN travel mascot, who wants to join you on your journey! This playful parrot makes a great travel companion, wherever the two of you may roam. You will also receive a Cory luggage tag that you can fill in with your contact information and attach to your medical supplies.

To see some of the places Cory has travelled, visit: facebook.com/coramhc/photos_albums — and feel free to post photos of your own!

WeNourish.com/Travel

facebook.com/coramhc/photo_albums

Cory took a trip to London! Where will you take him?
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WeNourish.com

• General information about the Nourish Nutrition Support Program
• Educational tutorials, videos and downloadable patient education tools
• Consumer events and teleconferences
• Online archive of Celebrate Life magazine
• Consumer resource links
• Local Coram branch maps and information

877.WeNourish (877.936.6874)
Call to speak to a TPN or tube feeding representative.

Nourish Advocacy Line
To reach a dedicated Consumer Advocate, call:
Toll-free 866.446.6373

Consumer Connect Conference Call Series
To view a schedule of upcoming conference call topics and times, visit:
WeNourish.com/events

Connect With Us

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