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***The Helping Ensure Life- and Limb-Saving Access
to Podiatric Physicians (HELLPP) Act***

HR 1221 / S 626

*Introduced by US Reps. Renee Ellmers (R-NC) and Diana DeGette (D-CO);
and US Sens. Chuck Grassley (R-IA) and Charles Schumer (D-NY)*

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As Congress considers options to modernize and strengthen the Medicare and Medicaid programs, the provisions of the common-sense, bipartisan *Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act* (HR 1221 / S 626) should be part of any discussion.

The HELLPP Act would improve Medicare and Medicaid health outcomes, enhance patient choices, and actually reduce the federal budget deficit.

The legislation would accomplish this by:

- 1. Recognizing podiatrists as physicians under Medicaid**—For more than 40 years, Medicare has defined doctors of podiatric medicine (DPMs, or podiatrists) as “physicians.” But this is not the case in Medicaid. Access to medical and surgical foot and ankle care *provided by a podiatrist* is considered optional and is not covered by all state plans, thus limiting Medicaid patient access to specialized foot and ankle medical and surgical care.

The HELLPP Act would bring Medicaid in line with Medicare (and a majority of US health-care delivery systems) and ensure Medicaid patients have access to care by the best educated and trained providers of foot and ankle care.

The legislation would not mandate new Medicaid services or benefits, nor would it require any Medicaid patient to seek care from a podiatric physician. It would not expand the scope of practice. It would simply provide that Medicaid patients have a full range of choices to see the physicians who are best trained for the foot and ankle care they seek.

- *Podiatric physicians and surgeons are licensed by their state boards to prescribe medication and perform surgeries, and deliver independent medical and surgical care without any supervision or collaboration requirement.*
- *Evidence shows that when DPMs are delivering foot and ankle care, outcomes are better, hospitalizations fewer and shorter, and the health-care system saves billions of dollars annually. Podiatric physicians and surgeons are often included in prominent public and private benefits packages. The Federal Employees Health Benefits Program (FEHBP), available nationally to federal employees, is one prime example of a benefits package which covers foot and ankle care by podiatrists.*

- *Under current law, foot and ankle care services are a covered benefit. However, when those services are provided by DPMs they can be teased out as “optional” coverage (“podiatry services”). This problem persists because podiatrists are not defined as “physicians” under Medicaid even though they have been defined as such under Medicare for more than 40 years.*
- *Currently, Medicaid effectively discriminates and can arbitrarily preclude patient access to a licensed and credentialed specialized physician class even though the services provided are covered benefits. Thus, Medicaid fails the basic tests of free market competition and patient choice.*

2. Clarifying and improving coordination of care in Medicare's Therapeutic Shoe Program for patients with diabetes—The current processes and Medicare contractor requirements for determining eligibility for Medicare's Therapeutic Shoe Program for patients with diabetes, and for furnishing this medically necessary benefit, are unnecessarily burdensome and frequently bogged down, leading to frustration on the part of the certifying physician, prescribing doctor, and supplier. The clarifications in the legislation would remove confusion and regulatory inconsistencies in the provision of this medically necessary benefit. They would allow each member of the collaborative team—MD/DO, DPM, and supplier—to work together more effectively and seamlessly on behalf of diabetic patients, resulting in less patient confusion, less provider frustration, and fewer office visits for the Medicare system.

- *Specifically, the language would allow Medicare to conform with the “real world” of health-care delivery concerning how therapeutic shoes for diabetic patients are diagnosed, evaluated, and furnished. The clarifications would statutorily legitimize and recognize the prescribing podiatrist's (and other qualified physician's) lower-extremity examinations, determination of foot pathology, and the medical necessity for therapeutic shoes/inserts when making a case (to CMS and auditors) for qualifying Medicare's therapeutic shoe and insert benefit for their patients with diabetes.*

3. Strengthening Medicaid program integrity through a fiscally responsible budget offset—By closing a loophole that allows tax-delinquent Medicaid providers to still receive full Medicaid reimbursements, this provision will save the Medicaid system money and more than offset any additional federal budget costs associated with the recognition of podiatrists as physicians under Medicaid. Such a mechanism already exists in Medicare so this could save billions of dollars for the public health-care system.

- *Under current law, Medicaid health-care providers who owe significant back taxes are still getting paid in full by Medicaid because of a loophole in the tax laws. The Government Accountability Office (GAO) conducted a study highlighting this irregularity, released July, 2012 (GAO-12-857): “Providers in Three States with Unpaid Federal Taxes Received over \$6 Billion in Medicaid Reimbursements.”*
- *This loophole has existed for a number of years, and several previous bipartisan bills have attempted to reform it.*
- *GAO estimates that the government could have recouped up to \$330 million in uncollected taxes due in 2009 in three states alone if the legal mechanisms were in place for Medicaid the way they are in Medicare to offset public program payments for federal taxes owed.*

The net result of implementing the HELLPP Act's common-sense reforms would be significant improvements to patient access to quality foot and ankle care, and meaningful savings for Medicaid and other parts of our health-care delivery system.

The Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act

Request

The American Podiatric Medical Association (APMA) requests you co-sponsor the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act, introduced by US Reps. Renee Ellmers (R-NC) and Diana DeGette (D-CO) (H.R. 1221), and US Sens. Chuck Grassley (R-IA) and Charles Schumer (D-NY) (S. 626).

Problem

The current Medicaid (Title XIX) statute covers physician services, including in most cases medical and surgical care of the foot and ankle. However, the definition of a physician is limited to care provided by a medical doctor (MD) or doctor of osteopathy (DO) as defined in 1861(r) (1) of the Social Security Act (SSA).

"Podiatric Services," which are not specifically defined in Medicaid (Title XIX) but are presumed to mean services provided by a Doctor of Podiatric Medicine (DPM), are considered optional, despite the fact that podiatric physicians are educated, trained, and licensed to perform the same foot and ankle care services as MDs and DOs. Doctors of podiatric medicine have been defined in the Medicare statute [1861(r)(3), SSA] as physicians for more than 40 years and are covered as providers in nearly all other federal health programs, including TRICARE, the Veterans Health Administration (VHA), and the Indian Health Service.

Background

Essential medical and surgical foot and ankle care is covered as a benefit by Medicaid programs in all 50 states and the District of Columbia, but it is not always covered when provided by a doctor of podiatric medicine. Current law effectively limits Medicaid beneficiaries' access to the quality, cost-effective services provided by podiatrists and discriminates against the type of licensed medical professional Medicaid patients might see for foot and ankle care.

The Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act would save lives, limbs, and money for the Medicaid program—for both states and the federal government. A higher-than-average percentage of Medicaid beneficiaries are at risk for diabetes and related lower limb complications.

Thomson Reuters, which provides industry expertise and critical information to decision makers in financial, legal, tax and accounting, and health-care areas, conducted a three-year study (accessible at: www.tinyurl.com/trstudy) that arrived at, among others, the following conclusions:

- Patients with diabetes in the general population seen by a podiatrist prior to a foot ulcer diagnosis had a 20-percent lower risk of amputation and a 26-percent lower risk of hospitalization than those not seen by a podiatrist

- Medicare-eligible patients with diabetes seen by a podiatrist had a 23-percent lower risk of amputation and a 9-percent lower risk of hospitalization compared with those not seen by a podiatrist
- For the general population, each dollar invested in care by a podiatrist results in up to \$51 of savings
- For the Medicare-eligible population, each dollar invested in care by a podiatrist results in up to \$13 of savings.

Treatment costs for diabetic foot ulcers range between \$7,439 and \$20,622 per episode. Estimated costs for a limb amputation are \$70,434, and can cost as much as \$500,000 over a lifetime. The potential and very significant cost savings of ensuring access to podiatric physicians in all sectors of the health care system—including Medicaid—cannot be disregarded.

Strong Bipartisan & Outside Support

Removing barriers for patient access to podiatric physicians has enjoyed strong bipartisan support in Congress, with bill language previously garnering 32 Senate cosponsors and 220 House cosponsors.

It was included in the Senate Finance Committee's initial Chairman's mark of the Deficit Reduction Act of 2005 and in one of the major health reform proposals in 2009, and in the US Senate's main SGR reform bills. The provision has also received past support from a diverse group of health-care stakeholders including the National Hispanic Medical Association and the American Public Health Association.

Cost

The Congressional Budget Office (CBO) provided an estimate of the Medicaid portion of the bill in 2009. The score was \$200 million over ten years, but did not examine savings that would result from the avoidance of unnecessary hospitalization or prevention of lower extremity amputations and assumed a greatly expanded Medicaid-eligible population. In 2014, CBO issued an updated score of the Medicaid and Medicare provisions, dramatically inflating its estimate to \$1.3 billion over ten years. This estimate must be revisited because CBO mistakenly interpreted both provisions to be expansions of existing programs.

Current Medicaid may deny patient access to the licensed and credentialed medical and surgical specialty care provided by podiatric physicians, even though the care they provide – foot and ankle care – is a covered benefit.

Podiatric Medicine: Expertise in Foot and Ankle Care

Doctors of podiatric medicine are podiatric physicians and surgeons, qualified by their education, training, and experience to diagnose and treat conditions affecting the foot, ankle, and related structures of the leg.

- Podiatric medicine is a medical sub-specialty, focused on a specific part of the anatomy similar to other highly focused sub-specialties, such as ophthalmology, cardiology, and otolaryngology.
- Within the field of podiatric medicine and surgery, podiatrists can focus on specialty areas such as surgery, sports medicine, biomechanics, geriatrics, pediatrics, orthopedics, or primary care.

Doctors of podiatric medicine have the education, training, experience, and licensure to:

- perform comprehensive medical history and physical examinations;
- prescribe drugs and order and perform physical therapy;
- perform surgeries ranging from basic to complex reconstructive surgery;
- repair fractures and treat sports-related injuries;
- prescribe and fit orthotics, durable medical goods, and custom-made shoes; and
- perform and interpret X-rays and other imaging studies.

Podiatric Medical Education

Doctors of podiatric medicine receive basic and clinical science education and training comparable to that of medical doctors:

- Four years of undergraduate education focusing on life sciences
- Four years of graduate study in one of the nine podiatric medical colleges
- At least three years of postgraduate, hospital-based residency training

The education, training, and experience podiatrists receive in the care and treatment of the lower extremity is more sophisticated and specialized than that of broadly trained medical specialists.

Comparison of Physician Education, Training and Practice

Degree	4 Year Graduate Medical Education	Minimum 3 Year Residency	Independently Diagnose and Treat (Office)	Independently Diagnose and Treat (Hospital)	Surgical Privileges (Hospital)	Admitting (H&P) Privileges	Full Rx License
Doctor of Podiatric Medicine (DPM)	•	•	•	•	•	•	•
Medical Doctor (MD)	•	•	•	•	•	•	•
Doctor of Osteopathic Medicine (DO)	•	•	•	•	•	•	•

The Majority of Foot/Ankle Care in the U.S. is Performed by Podiatric Physicians but Medicaid Patients May Not Have Access

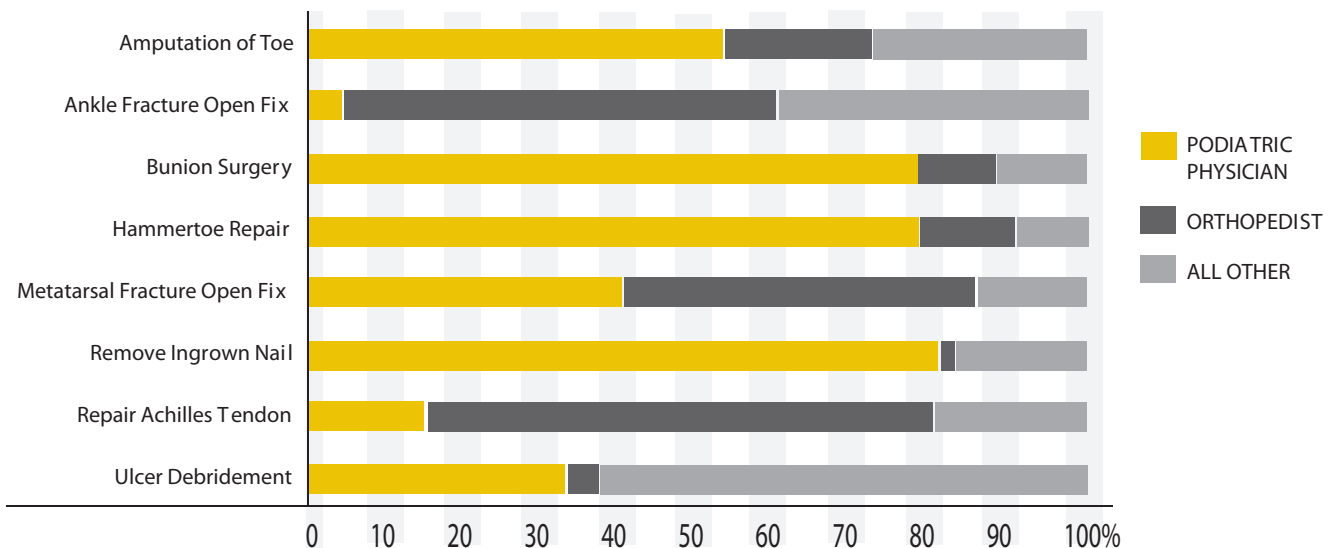
For foot and ankle issues, most Americans seek out specialists for their care, typically a Doctor of Podiatric Medicine, an orthopedist, or other physician. The majority of medical care of the foot and ankle is performed by podiatrists.

Even though foot and ankle care is generally a covered benefit under Medicaid, the program currently teases out a separate podiatry benefit as being “optional” for patients, focusing on the provider of services, rather than ensuring coverage of medically necessary care regardless of the qualified professional furnishing such care. Thus, Medicaid effectively discriminates and can arbitrarily preclude patient access to a licensed and credentialed specialized physician class even though the services they provide—foot and ankle care—are a covered benefit.

Whenever public or private health insurance programs preclude patient access to podiatric physicians, there are adverse impacts on our health-care delivery system:

1. Costs increase by driving patients to a more expensive point of service (e.g., hospital emergency rooms) for the same services.
2. It exacerbates America’s growing physician shortage by not appropriately utilizing the full range of physician specialists.
3. It denies patients the option of seeing the physicians who are best trained for the foot and ankle care they seek.

COMMON FOOT & ANKLE PROBLEMS TREATED BY PHYSICIANS



Source: Thomson Reuters Market Scan survey data for 2010 commercial health insurance claims

Fact Sheet: Studies Prove Podiatrists Prevent Complications, Provide Savings

According to the CDC, nearly 26 million Americans live with diabetes. Diabetes is the leading cause of non-traumatic lower-limb amputation; however, amputations can be prevented. Two peer-reviewed published studies evaluated care by podiatrists for patients with diabetes and demonstrated that compared to other health-care professionals, podiatrists are best equipped to treat lower extremity complications from diabetes, prevent amputations, reduce hospitalizations, and provide savings to our health-care delivery systems.

Access to a Podiatrist Can Lead to Savings for US Health-Care Delivery Systems

According to a study conducted by Thomson Reuters Healthcare (accessible at: www.tinyurl.com/trstudy) that compared outcomes of care for patients with diabetes treated by podiatrists versus care provided by other health-care professionals and physicians published in the Journal of the American Podiatric Medical Association¹:

- Among patients with commercial insurance, a savings of \$19,686 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding a diabetic ulceration. Diabetic ulcerations are the primary factor leading to lower extremity amputations. Among patients with commercial insurance, each \$1 invested in care by a podiatrist results in \$27 to \$51 of savings for the health-care delivery system.
- Among Medicare-eligible patients, a savings of \$4,271 per patient with diabetes can be realized over a three-year period if there is at least one

visit to a podiatrist in the year preceding ulceration. Among Medicare eligible patients, each \$1 invested in care by a podiatrist results in \$9 to \$13 of savings.

- Conservatively projected, these per-patient numbers support an estimated \$10.5 billion in savings over three years if every at-risk patient with diabetes sees a podiatrist at least one time in the year preceding the onset of an ulceration.

Care by a Podiatrist Can Reduce the Risks and Prevent Complications from Diabetes

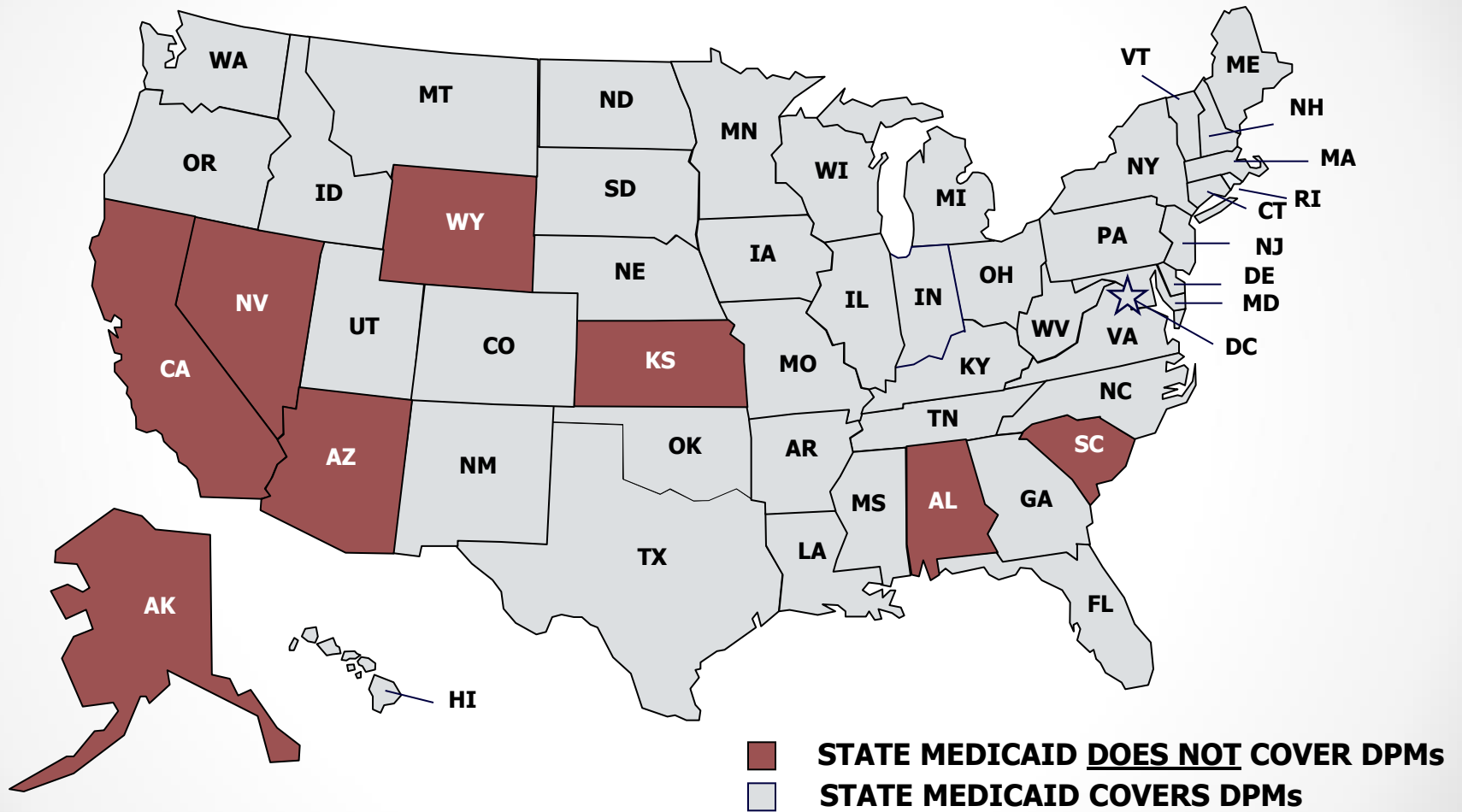
According to an independent study conducted by Duke University published in Health Services Research²:

- Medicare-eligible patients with diabetes were less likely to experience a lower extremity amputation if a podiatrist was a member of the patient-care team.
- Patients with severe lower extremity complications who only saw a podiatrist experienced a lower risk of amputation compared with patients who did not see a podiatrist.
- A multidisciplinary team approach that includes podiatrists most effectively prevents complications from diabetes and reduces the risk of amputations.

¹ Ginger Carls et al., "The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers," Journal of the American Podiatric Medical Association 101 (2011): 93-115, accessible at: www.tinyurl.com/trstudy.

² Sloan, F. A., Feinglos, M. N. and Grossman, D. S., RESEARCH ARTICLE: Receipt of Care and Reduction of Lower Extremity Amputations in a Nationally Representative Sample of U.S. Elderly. Health Services Research, no. doi: 10.1111/j.1475-6773.2010.01157.x

HOLES IN THE SAFETY NET



SOURCE: American Podiatric Medical Association, March 2016

**Diverse Health-Care Stakeholder and Patient Advocacy
Groups Endorsing the HELLPP Act:**

American Public Health Association

Association for the Advancement of Wound Care

California Medical Association

Diabetes Advocacy Alliance *

National Hispanic Medical Association

Office and Professional Employees International Union

Peripheral Arterial Disease Coalition

Society for Vascular Surgery

Vascular Disease Foundation

* The following groups comprise the Diabetes Advocacy Alliance: Academy of Nutrition and Dietetics; American Association of Clinical Endocrinologists; American Association of Diabetes Educators; American Clinical Laboratory Association; American Diabetes Association; American Medical Association; American Optometric Association; American Podiatric Medical Association; Diabetes Hands Foundation; Endocrine Society; Healthcare Leadership Council; National Association of Chain Drug Stores; National Association of Chronic Disease Directors; National Community Pharmacists Association; National Kidney Foundation; Novo Nordisk, Inc.; Omada Health; Pediatric Endocrine Society; Weight Watchers International, Inc.; YMCA of the USA; VSP® Vision Care

For copies of these letters of endorsement, please visit:

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The Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians Act
114th Congress

Cosponsors (138): HR 1221 (127) S 626 (11)

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Updated: May 2, 2016

113th Congress

Cosponsors (135.): H.R. 1761 (124) S. 1318 (11)

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Updated December 16, 2014

Arizona Medicaid Study: Exclusion of Podiatric Physicians and Surgeons Adversely Impacted Diabetic Patient Health, Program Finances

Arizona's decision to jettison Medicaid patient access to doctors of podiatric medicine (also referred to as DPMs, or podiatrists) has led to a "marked worsening of outcomes and cost for patients with diabetic foot infections," according to a new peer-reviewed study released at the 73rd Scientific Sessions of the American Diabetes Association (June, 2013).

The study concludes that each \$1 of Medicaid program "savings" the state anticipated from the elimination of podiatric medical and surgical services actually increased costs of care by \$48.

In [*Foot in Wallet Disease: Tripped up by "Cost Saving" Reductions*](#), researchers Grant H. Skrepnek, PhD, RPh, Joseph L. Mills, MD, and David G. Armstrong, DPM, MD, PhD, analyzed data for all Medicaid diabetic foot infection hospital admissions across the state over five years (2006—2010), a time period before and after the state's decision in 2009 to exclude DPMs from its Medicaid program.

The study found a significant decline in quality outcomes and higher program expenditures among those diagnosed with a diabetic foot infection, including:

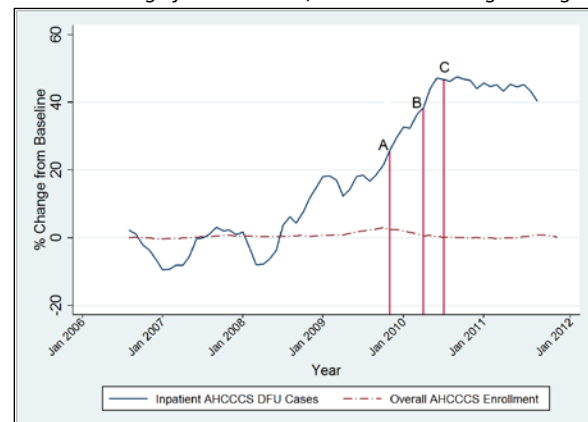
- **37.5-percent increase** in diabetic foot infection hospital admissions;
- **28.9-percent longer** lengths of patient stay;
- **45.2-percent higher** charges, and
- a nearly **50-percent increase** in severe aggregate outcomes

(e.g., death, amputation, sepsis, or surgical complications).

Importantly, the data reveal that the vast majority of the worsening of diabetic foot infection patient health outcomes and increased costs occurred during the 2009—2010 time window, coinciding with Arizona's policy change to exclude patient access to foot and ankle care provided by DPMs.

Inpatient Diabetic Foot Infections among Arizona Medicaid Beneficiaries 2006—2010

Percent Change from Baseline, Six-Month Moving Average



Timepoint A: Announced recommendation to eliminate reimbursements to podiatrists within Arizona Health Care Cost Containment System, AHCCCS (i.e., Arizona Medicaid); Arizona 49th Legislature SB 1003 and HB 2003 [OCTOBER 2009]

Timepoint B: Arizona 49th Legislature SB 1003 and HB 2003 legislation signed [MARCH 2010]

Timepoint C: Official date of podiatric service coverage elimination [JUNE 2010]

Policy Implications for Modernizing Medicaid

Arizona's Medicaid experience underscores the compelling policy rationale for removing patient access barriers to podiatric physicians and surgeons. The Arizona study complements two additional, separate studies that found that when podiatrists are administering medical and surgical foot and ankle care, outcomes are better, hospitalizations are fewer and shorter, and the health-care system saves billions of dollars annually.¹

The unfortunate counterproductive experience that embroiled Arizona is also happening in other states around the country. The core problem persists because podiatrists are not defined as "physicians" under Medicaid, even though they have been defined as such under Medicare for more than 40 years and are recognized as such throughout most of the US health-care system.

Doctors of podiatric medicine prescribe medication, perform surgeries, and are licensed by their state boards to deliver independent medical and surgical care

¹ "The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers", Journal of the American Podiatric Medical Association, Vol. 101, No 2, March/April, 2011; and

Sloan, F.A., Feinglos, M.N. and Grossman, D.S., RESEARCH ARTICLE: *Receipt of Care and Reduction of Lower Extremity Amputations in a Nationally Representative Sample of U.S. Elderly*. Health Services Research, no. doi: 10.1111/j.1475-6773.2010.01157.x

Details of both studies accessible at:
www.APMA.org/saving; ["Fact Sheet: Studies Prove Podiatrists Prevent Complications, Provide Savings"](#)

without any supervision or collaboration requirement.

Ironically, Medicaid only ensures coverage of necessary foot and ankle care if provided by a medical doctor (MD) or a Doctor of Osteopathy (DO). But Medicaid coverage for foot and ankle care provided by DPMs is *optional* for states, meaning "podiatry services" are teased out and classified as an "optional" benefit.

Under current law, states are under constant pressures to curtail "optional services" like patient access to podiatrists in a "penny wise/pound foolish" attempt to trim Medicaid budgets.

But as this Arizona Medicaid study indicates, doing away with "podiatry services" is a classic demonstration of the law of unintended consequences.

A Common-Sense, Bipartisan Solution to Provide Cost Savings to Medicaid

Unnecessarily higher Medicaid spending by states also translates to unnecessarily higher spending by the federal government, because Medicaid is financed jointly by the federal government and the states. The federal government matches state Medicaid spending.

To address this long-standing counterproductive state churning of "optional" access to podiatric physicians and surgeons, US Representatives Renee Ellmers (R-NC) and Diana DeGette (D-CO), and US Senators Chuck Grassley (R-IA) and Charles Schumer (D-NY) have introduced the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act (HR 1221 / S 626). This bipartisan legislation would help modernize and strengthen

Medicaid by recognizing, at long last, podiatrists as physicians under Medicaid, thereby enhancing patient choices and access, and improving health outcomes for those in need of specialized foot and ankle care. The bill also would improve aspects of care coordination in Medicare's diabetic shoe program, and strengthen Medicaid program integrity by offsetting government reimbursements for any unpaid federal taxes owed by health providers with prolonged federal tax delinquency issues.

As Arizona Medicaid has shown, maintaining a separate optional podiatry benefit has had significant negative health effects on patients with diabetes. State (and by extension, federal) Medicaid spending is not reduced, but merely redistributed to another setting or provider, often with adverse consequences for patient health and health costs.

The current ever-changing patchwork of Medicaid patient access has the effect of limiting access to timely and appropriate foot and ankle care, at a time when the US is already facing a growing physician

shortage. So long as our public policy focus is on the type of provider rendering foot and ankle care, instead of ensuring the coverage of medically necessary foot and ankle care, preventable chronic conditions will become an even greater cost burden for Medicaid.

In virtually all other health-care settings—Medicare, private employer coverage, Federal Employees Health Benefits (FEHBP), TRICARE, the Veterans Administration, and the Indian Health Service—patient access to specialized podiatric medical and surgical care is ensured. Medicaid is the glaring exception.

As Congress considers options to modernize and strengthen the Medicare and Medicaid programs, the provisions of the common-sense, bipartisan HELLPP Act should be part of any discussion. The legislation represents a sound policy rationale in making the commitment to ensure timely patient access to specialty medical and surgical foot and ankle care.

CBO Should Revisit Cost Estimate of The Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act

The Congressional Budget Office (CBO) prepared a cost estimate of S. 1871, the “SGR Repeal and Medicare Beneficiary Improvement Act of 2013”, as reported by the Senate Finance Committee on January 16, 2014 which included two provisions related to podiatric physicians (Sec. 254). The American Podiatric Medical Association (APMA) takes strong exception to CBO’s budgetary impact estimate of Section 254, provisions from the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act, and urges CBO to review the provisions and APMA’s supporting documentation.

The CBO estimate states that:

“Section 254 would promote Medicaid beneficiary access to podiatrists and expand Medicare coverage of therapeutic shoes for beneficiaries with diabetes. CBO estimates that those changes would increase direct spending by about \$1 billion between 2014 and 2023.”

CBO acknowledges that:

“Because Medicaid provides states with significant flexibility to make programmatic adjustments in response to such changes in requirements, the [requirement to include podiatrists as physicians under the Medicaid program] would not be [an] intergovernmental mandate as defined in UMRA [the Unfunded Mandates Reform Act].”

APMA believes the HELLPP Act provisions warrant a closer look by the CBO. *The estimate incorrectly describes the Medicare provision as expanding coverage.* On the contrary, the Medicare provision of the HELLPP Act is a paper-work clarification of the current Medicare benefit to better account for how medical professionals certify, prescribe, dispense services, and maintain records under the Medicare diabetic shoe benefit. Underscoring this point, a rule of construction has been incorporated into the current version of the HELLPP Act clarifying that the legislative language should not be construed as expanding coverage under the Medicare diabetic shoe program.

APMA also believes the federal budgetary impact of defining podiatrists as physicians under Medicaid should be significantly lower than what CBO recently estimated. In fact, in 2009, CBO reviewed the very same provision in the context of a much broader Medicaid expansion proposal and estimated it would cost \$200 million over 10 years. However CBO’s recent estimate inexplicably inflated its previous estimate even in light of the following changes to the Medicaid landscape since then:

- Medicaid expansion population is smaller. The Affordable Care Act (ACA) expands coverage to only 133% of the Federal Poverty Level (FPL), while the 2009 legislation CBO was analyzing called for Medicaid expansion for a larger population of up to 150% FPL.
- Medicaid expansion under the ACA is optional as determined by Supreme Court ruling. CBO estimated that the ruling would cause 6 million fewer people to be enrolled in Medicaid and would reduce overall Medicaid spending by \$289 billion over 10 years.
- Numerous peer-reviewed studies demonstrate that care by podiatrists improves patient outcomes and reduces hospitalizations, saving the health-care system from significant unnecessary costs.

Understanding CBO may not revisit and revise its estimate, the HELLPP Act includes a provision to offset any increased spending by closing a loophole so that Medicaid payments to tax-delinquent Medicaid providers would be reduced by the amount of federal taxes that are owed. Such a mechanism already exists in Medicare and is supported by a Government Accountability Office (GAO) study highlighting this irregularity, released July, 2012 (GAO-12-857): “Providers in Three States with Unpaid Federal Taxes Received over \$6 Billion in Medicaid Reimbursements.”

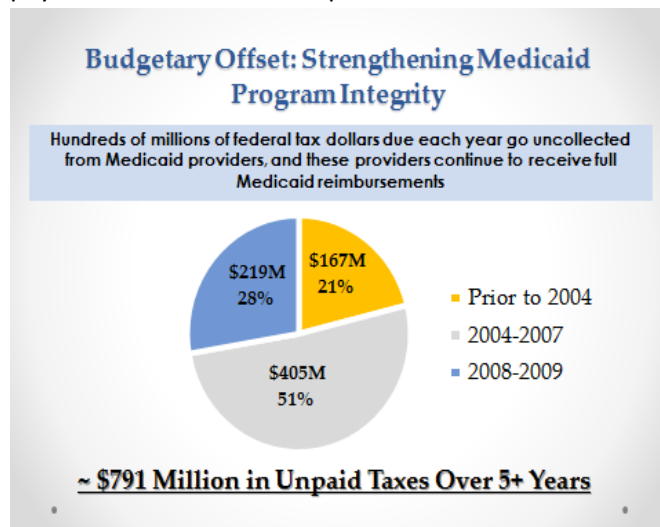
Fact Sheet: Strengthening Medicaid Program Integrity Budget Savings in the Bipartisan HELLPP Act (HR 1221 / S 626)

The bipartisan “Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act” (HR 1221 / S 626) would enhance patient access to podiatric physicians and surgeons and improve quality outcomes by recognizing doctors of podiatric medicine (DPMs) as physicians under Medicaid, and removing regulatory inconsistencies and confusion in Medicare’s diabetic shoe program.

The bill would also strengthen Medicaid program integrity and provide federal budget savings through a common-sense reform recommended by the US Government Accountability Office (GAO) in its July 2012 report: “Providers in Three States with Unpaid Federal Taxes Received over \$6 Billion in Medicaid Reimbursements” (July 2012, GAO-12-857).

THE PROBLEM: Health-care providers who owe significant back taxes for years may still receive full Medicaid payments because of a loophole in the tax laws. Under Medicare and most federal programs, the Internal

Revenue Service can garnish, or offset, federal payments when a health-care provider has an unpaid tax bill, but Medicaid’s state-based system has prevented its payments from qualifying as a federal payment.



The GAO responded to a bipartisan senate request regarding this anomaly and found that “for the 7,000 delinquent Medicaid providers we identified in three states (Florida, New York and Texas), if there had been such an automated continuous levy system in place [similar to what exists in Medicare], we estimate that between \$22 million and \$330 million could have been collected to offset unpaid federal taxes in 2009.”

FEDERAL PAYMENT LEVY PROGRAM: Through the Federal Payment Levy Program, established in July 2000, the IRS can collect overdue taxes through a continuous levy on certain Federal payments; this includes Medicare fee-for-service payments. This levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. As of February 15, 2013, the Centers for Medicare and Medicaid Services (CMS) has realized a cumulative total of over \$193 million in tax levy offsets.

HELLPP ACT BUDGET SAVINGS: The HELLPP Act includes a provision to close this tax loophole, **allowing for improved collection of outstanding tax debts from Medicaid providers.** The provision — which has been offered in several bipartisan bills in the past — would add Medicaid to the definition of “federal payment,” thereby extending the federal government’s continuous levy mechanism to cover payments to Medicaid providers or suppliers.

If such a program integrity mechanism could be used in Medicaid similar to the way it is used in Medicare, GAO estimates that **between \$22 million and \$330 million in owed unpaid federal taxes could have been collected in the selected three states in 2009.**

Tax delinquents still drawing Medicaid pay, GAO reports

■ **At least 7,000 health care professionals in three states received more than \$6 billion in total Medicaid payments despite owing back taxes.**

By [Jennifer Lubell](#) amednews staff— Posted Aug. 10, 2012

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Washington Health care professionals who owe significant back taxes for years still are getting paid by Medicaid because of a loophole in the tax laws, the Government Accountability Office concluded in a report issued Aug. 2.

GAO investigated known federal tax debts owed by Medicaid health care professionals in Florida, New York and Texas — three states whose Medicaid programs received some of the largest allotments of money from the 2009 federal stimulus package. The agency found that roughly 7,000 were delinquent on nearly \$800 million in federal taxes from 2009 or earlier but had been paid a total of more than \$6 billion by Medicaid. Because the estimates didn't include entities that either had underreported their income or failed to file tax returns, the watchdog agency expects that the amount of unpaid taxes was even higher.

The report also profiled 40 Medicaid health care professionals or businesses that had sizable federal tax debts in these states. GAO found that they collectively had received a total of \$235 million in pay in 2009 even though they owed nearly \$26 million in taxes to the federal government through 2010. Physicians, dentists, hospitals, home care providers, durable medical equipment suppliers and social services providers were among those represented in this case study. Some of these entities, which were not identified by name in the report, had been associated with potential criminal activity or abuse of the federal tax system, according to GAO.

The people profiled are tax cheats, said Sen. Tom Coburn, MD (R, Okla.), the lead Republican on the Senate Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations. GAO's findings underscore a need to raise the integrity of the Medicaid program, said Dr. Coburn, who requested the report along with other leaders on the committee and the Senate Finance panel.

"It's unfortunate that this much was identified as unpaid taxes, because that's revenue that could provide care to people," said Glen Stream, MD, president of the American Academy of

Family Physicians. “We expect people to be good citizens and pay their taxes, including physicians.”

But because Medicaid doesn’t pay very well, Dr. Stream suggested that some of the tax delinquency might involve practices being in a state of financial distress. While this isn’t an excuse, he said, “there may be more understandable reasons than egregious financial behavior.”

The Internal Revenue Service can garnish federal payments when the recipient has an unpaid tax bill, but Medicaid’s state-based system has kept its pay from qualifying as a federal payment. “IRS currently may only subject Medicaid reimbursements to a one-time levy instead of a continuous levy,” GAO stated. The report cited an example of a physician who had received more than \$200,000 in Medicaid pay but owed more than \$500,000 in unpaid federal taxes. The IRS ended up having little success in placing a levy on this physician’s Medicaid payments.

GAO estimates that the IRS could have recouped up to \$330 million in these three states if it had been able to issue continuous levies on Medicaid payments. But given the difficulties they face just in processing one-time levies, state officials interviewed by GAO expressed doubts about using continuous levies.

GAO has investigated similar problems in the Medicare program. In 2007, the agency reported that 21,000 physicians in 2005 had been paid by the program despite owing a total of more than \$1 billion in back payroll and income taxes.

The most recent report can be viewed online ([link](#)).

Clarifying and Strengthening Coordination of Care in the Medicare Diabetic Shoe Program

In order for a patient to be eligible for Medicare's Diabetic Shoe Program, a physician (MD or DO) must certify that the patient has diabetes mellitus, that the patient is being treated under a comprehensive plan of care for diabetes, and that it would be medically necessary for the diabetic patient to have therapeutic diabetic shoes.

The MD or DO physician who is treating the patient's systemic diabetes condition must currently also certify that the patient qualifies at least one of six lower extremity conditional findings for diabetic shoes/inserts eligibility:

- a. Previous amputation of the other foot, or part of either foot; or
- b. History of previous foot ulceration of either foot; or
- c. History of pre-ulcerative calluses of either foot; or
- d. Peripheral neuropathy with evidence of callus formation of either foot; or
- e. Foot deformity of either foot; or
- f. Poor circulation in either foot.

In practice, a podiatrist — a doctor of podiatric medicine (DPM) — or an orthopedist, is the one who performs the patient's detailed lower extremity examination qualifying at least one of these six conditional findings. In doing so, it is the podiatrist or orthopedist who typically identifies medical necessity (and writes the prescription/order for diabetic shoes/inserts) and initiates contact with and reports requisite information to the patient's physician (e.g., the certifying MD/DO).

Podiatrists/orthopedists are finding that their medical records, which contain more detailed lower extremity examination findings than the MD/DO's records, are either being discounted or completely ignored by the DME Medicare Administrative Contractors (DMACs), Contractor Medical Directors, and auditors when records are submitted for qualifying their patient for the therapeutic shoe and insert benefit. Refunds are being asked from the suppliers (both podiatrist-suppliers and commercial suppliers). Recent rates of audit claims error/denials are alarmingly high. Some recent reviews reveal 85% to 97% of the audited claim submissions are being denied by regulators and auditors who have been following narrow DMAC Local Cover-

age Determination policies. (APMA has received anecdotal evidence that a large number of these decisions are being overturned "favorably" by administrative law judges.)

For several years, APMA has discussed these problems with CMS and the DMACs, and while they are sympathetic, they have said that any remedy must come from a statutory change.

APMA members are becoming increasingly frustrated with this status quo, with a number now dropping their participation in the Medicare Diabetic Shoe Program and many others considering no longer serving as suppliers. The anticipated consequences include reduced or progressively difficult access to this medically necessary and appropriate benefit for diabetic patients.

APMA has identified some minor balanced improvements to clarify provider roles and remove confusion and regulatory inconsistencies in the provision of this medically necessary benefit. These clarifications would preserve the integrity of the checks and balances in the diabetic shoe/insert program. MDs or DOs who are treating the patient's diabetes would certify that the patient is under a comprehensive program of management of the disease; podiatrists/orthopedists would determine medical necessity for diabetic therapeutic shoes and inserts and prescribe those shoes and inserts; suppliers would fit, provide, and evaluate fit of the shoes and inserts. Under this proposal, the roles of the MD, DO, and DPM would, however, be clarified, thereby strengthening their coordination of care and communication in treating Medicare diabetic patients.

These targeted reforms would amend § 1861(s)(12) of the Social Security Act to clarify roles and improve communications among medical providers. They will significantly reduce the frustrations of the physicians and suppliers over the current administrative policies of the Medicare Diabetic Shoe Program, help ensure that those Medicare patients who are most at risk and eligible for this benefit receive it, and obviate Medicare diabetic patients making additional office visits, which in turn would save money for patients/beneficiaries and the Medicare program.

FOOTWEAR MATTERS

Foot problems associated with diabetes are a significant portion of the health risk and cost.

IMPAIRED SENSATION OR FOOT PAIN

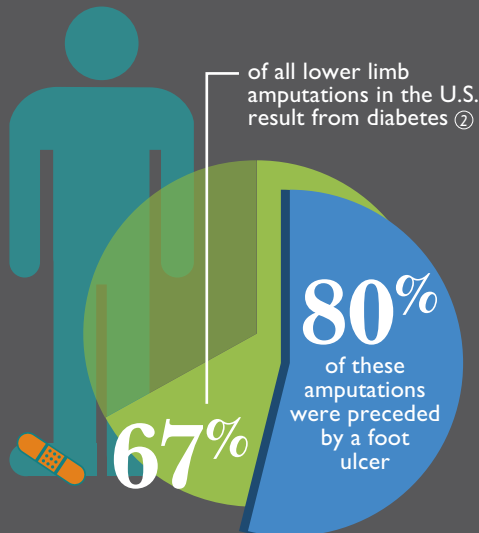
60%-70%

of diabetes patients have mild to severe forms of nervous system damage

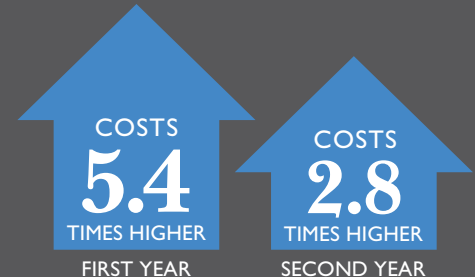
CAN CAUSE

impaired sensation or pain in the feet
①

RISK OF AMPUTATIONS



HIGH COSTS FOR FOOT ULCER CARE



AFTER FIRST FOOT ULCER

Compared with diabetic patients without foot ulcers ③

① Center for Diseases Control (CDC) "National Diabetes Fact Sheet, 2011" ② The costs of diabetic foot: The economic case for the limb salvage team. *Journal of Vascular Surgery* 2010;52:17S-22S; Reiber G. Epidemiology and Health Care Costs for Diabetic Foot Problems. In: Veves A, Giurini J, LoGerfo F, eds. *Diabetic Foot: Medical and Surgical Treatment*. Totowa, NJ: Humana Press; 2002;35-58 ③ The costs of diabetic foot: The economic case for the limb salvage team; Boston, Mass; and Georgetown, Tex.

Therapeutic footwear can decrease ulcers and amputations in diabetic patients

For many diabetes patients, not wearing therapeutic footwear isn't worth the risk.

FOOT CARE PROGRAMS



AMPUTATIONS

LOWERED
UP TO
85%

Programs include:

- Risk assessment
- Foot-care education and preventive therapy
- Treatment of foot problems
- Referral to specialists ①

THERAPEUTIC FOOTWEAR



FOOT ULCERS

LOWERED
12%

AMPUTATIONS

LOWERED
18%

AFTER 2 YEARS

- Examined the impact of therapeutic footwear on diabetic complications (foot ulcers and amputations)
- Patients with Type 2 Diabetes mellitus (T2DM)
- Sample size = 26,437 people
- Compared same patient, pre and post therapeutic footwear usage
- Followed patients for 1 year before and 2 years after receiving therapeutic shoes ④

CUSTOM ORTHOTIC INSOLES



FOOT
REULCERATIONS

LOWERED
TO
15%

AMPUTATIONS

LOWERED
TO
6%

AFTER 2 YEARS

- 79% reulceration rate before treatment
- 54% amputation rate before treatment ⑤

④ Minshall ME, Durden E, Huse DM, McMorrow D, Lidtke RH. Characteristics and Health Care Resource Utilization of Type 2 Diabetes Mellitus (T2DM) Patients Using Therapeutic Footwear. *Diabetes*, 2014; 63(Suppl. 1): A163. ⑤ How Effective Is Orthotic Treatment in Patients with Recurrent Diabetic Foot Ulcers? *Journal of the American Podiatric Medical Association* 2013;103:281-290.

Clarifying and Strengthening Coordination of Care in the Medicare Diabetic Shoe Program

The *Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act* (HR 1221 / S 626) contains a provision to remove regulatory inconsistencies and provider confusion in Medicare's Therapeutic Shoes for Diabetics program, thereby enabling providers to work more efficiently and seamlessly on behalf of the patients they serve.

Recent data from two DME Medicare Administrative Contractors strongly suggest a flawed and confusing process in the provision of Medicare diabetic shoes, and underscore the need for clarifications like the ones contained in the HELLPP Act.

Initial Claims Processing

	Region C (CIGNA Government Services)	Region D (Noridian)
	Q1 2014	
Denial Rate	80%	82%
Common Reasons for Denial	<ol style="list-style-type: none"> 1) Medical records from the certifying physician were not provided. (40%) 2) The clinician foot examination was performed by a clinician (another physician, podiatrist, nurse practitioner, clinical nurse specialist, physician assistant) other than the certifying physician and the certifying physician did not signify that he/she reviewed and agreed with the exam findings by stating approval and signing and dating the examination notes. (32%) ** 3) Documentation did not include a clinical foot exam. (13%) 4) The supplier's in-person evaluation of the beneficiary's feet was missing one or both of the following required elements: (1) Description of the abnormalities the shoes/inserts/modification need to accommodate; or (2) Measurements of the beneficiary's feet. (12%) 5) Documentation provided by the supplier did not include a copy of a detailed written order. (12%) 	<ol style="list-style-type: none"> 1) Documentation of foot abnormalities by certifying physician not met 2) Documentation of diabetes management by certifying physician not met 3) No documentation was received 4) Documentation of in-person visit prior to selection of items not met

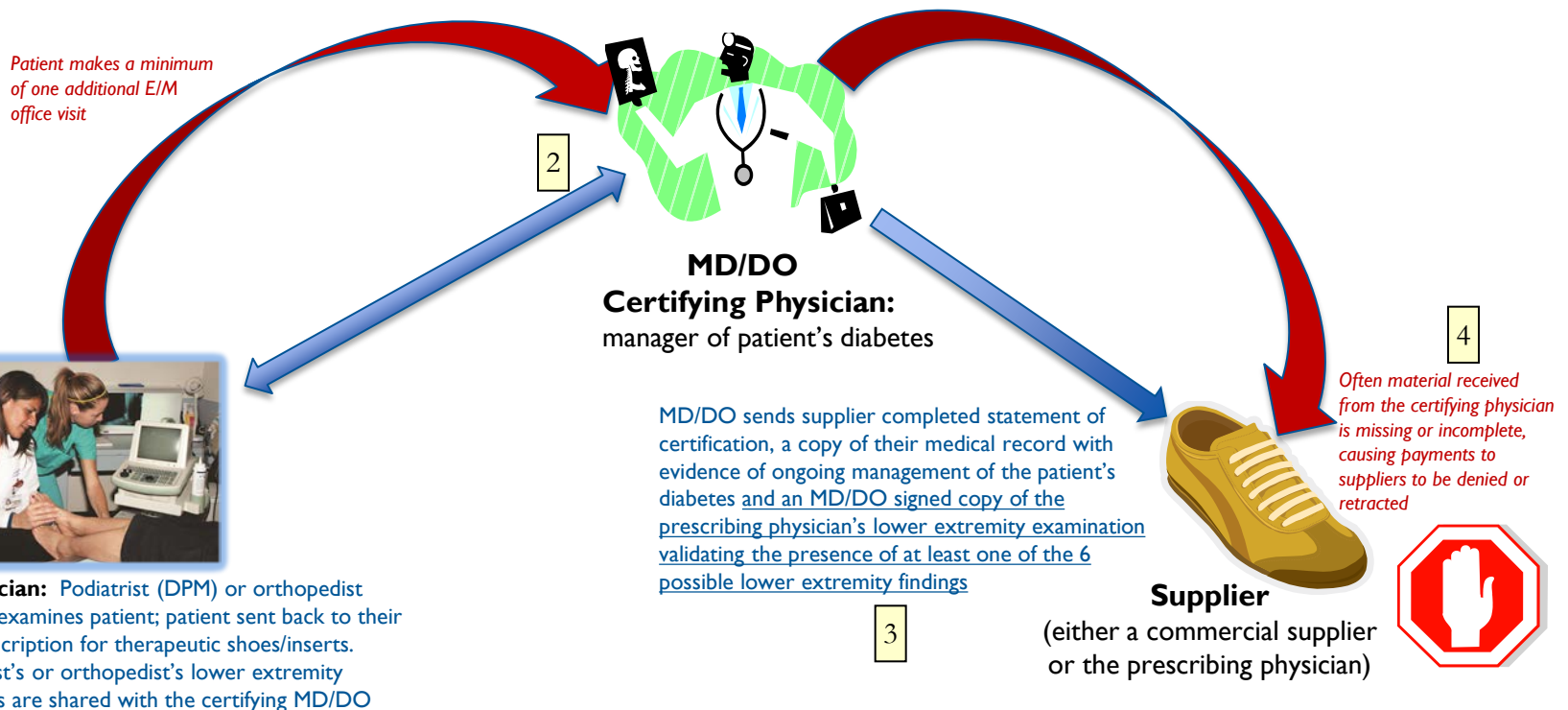
Error rates are generally calculated by reviewing each claim and determining if there was an error in any of the following, for example:

- Does the item/equipment fit a Medicare benefit category?
- Is the item/equipment statutorily excluded?
- Is the item/equipment medically reasonable and necessary?
- Is there documentation to support that the item/equipment was provided?
- Was the item/equipment coded and billed correctly?

Error rates of 80% or higher should be a concern to policymakers that either the review criteria is unclear or that the claims adjudication process itself is flawed. These error rates remain consistently high across the most recent quarters available (in excess of 75%).

**** The HELLPP Act would significantly improve some exceedingly high error rates by addressing Reason 2 under CIGNA (present in 32% of denials) and potentially Reason 1 under Noridian (percentages not available).**

Medicare's Therapeutic Shoe Program: Problems

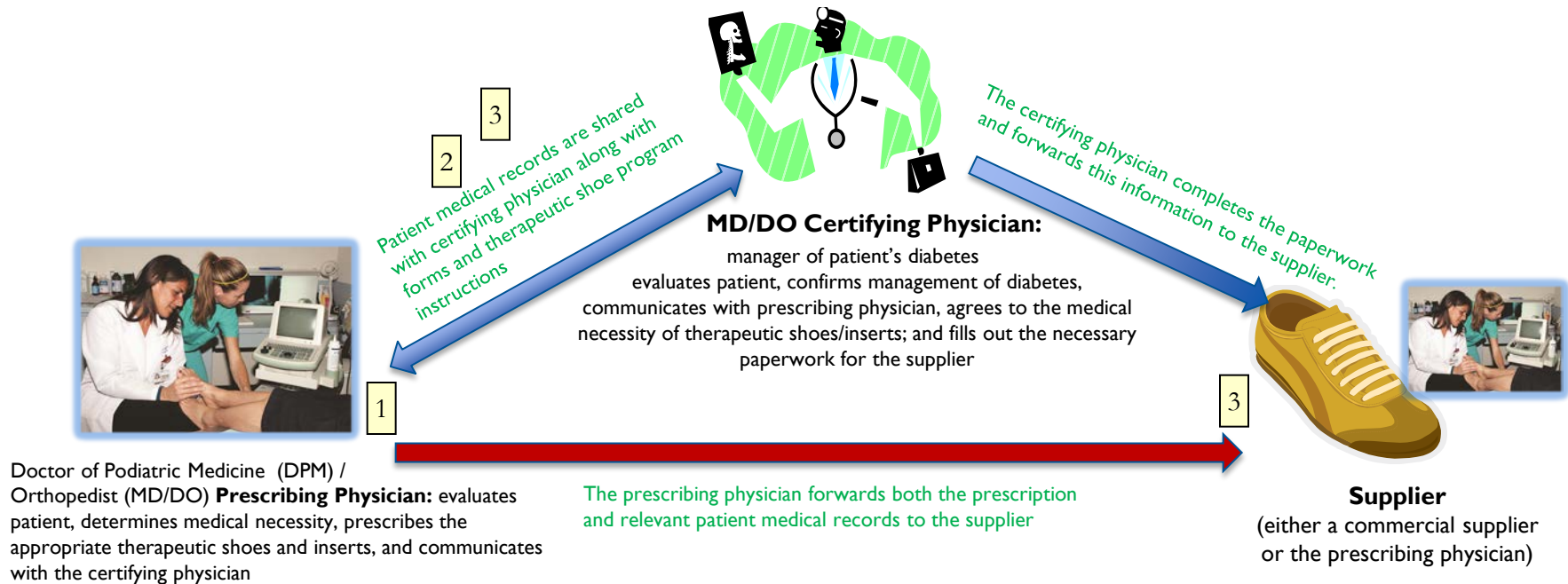


Overview of Process

1. DPM or orthopedist performs lower extremity evaluation, determines patient has one or more of 6 conditions, writes prescription for diabetic shoe(s).
2. Refers patient back to MD/DO managing diabetes. The prescribing physician forwards the prescription for the therapeutic shoe/inserts to the supplier as well as a copy of their medical record examination, information about the therapeutic shoe program, instructions for the certifying doctor, and the "statement of certification" form. Patient makes a minimum of one additional E/M office visit to complete the examination and certifying requirements, going BACK to the primary care physician because medical necessity and clinical findings of prescribing doctor are not recognized as valid by program auditors.
3. Medical records by DPM/orthopedist are not accepted as being valid or even complementary to managing physician's findings of medical necessity. Only physician managing diabetes can make medical necessity determination qualifying for therapeutic shoes. And their clinical findings are often incomplete.
4. Often suppliers are finding payments for therapeutic shoes/inserts could be denied or be retracted because of MD/DO medical documentation is incomplete.
5. If the prescribing physician (e.g., DPM or orthopedists) is not the supplier, likely 2 additional E/M services to be billed.

SUMMARY: Significant problems result in delayed patient care, increased patient and provider frustration, and unnecessarily higher Medicare expenditures.

Medicare's Therapeutic Shoe Program: Solution



Overview of Process

1. The prescribing physician (e.g., DPM or orthopedist) examines the patient, determines medical necessity, writes a prescription for the appropriate therapeutic shoes/inserts, and refers the patient to the supplier (either a commercial supplier or the prescribing physician [who may also act as supplier]).
2. The prescribing physician shares his/her patient medical records with the certifying physician along with relevant forms and instructions for the certifying physician on the therapeutic shoe program requirements.
3. The certifying physician (MD/DO) reviews his/her patient medical record, as well as the prescribing physician's medical record, and agrees with the medical necessity for the therapeutic shoes/inserts. The certifying physician may attest to medical necessity or may call for additional patient visit. Forwards a completed statement of certification and copies of the relevant medical record to the supplier. The prescribing physician shares patient medical records with certifying physician and forwards the prescription for the appropriate therapeutic shoes/inserts and relevant medical record to the supplier. The supplier proceeds fitting and furnishing the prescribed shoes/inserts once all the required and appropriate paperwork is received.

Reform Summary

- Reforms clarify that patient does not need a certifying physician visit to establish if a patient can be seen by the prescribing physician; the prescribing physician (the lower extremity specialist) is already treating the patient and their his/her records can optionally serve as evidence of clinical lower limb qualification; the certifying physician must agree (checks and balance) to the medical necessity of the therapeutic shoes; and there is a maintenance that the certifying physician (MD/DO) is the only party that can qualify the statement of certification.
- Reforms clarify that additional patient office visits to certifying physician are not required but are up to the certifying physician's discretion if necessary. Reforms eliminate unnecessary steps – extra visits – confusion, and frustration over the administration of this program. Wasted time and unnecessary spending are eliminated. Fraud and abuse program safeguards remain in place.

Side by Side Comparison of Current Law vs. HELLPP Act (HR 1221 / S 626)

Current Law	HR 1221 / S 626	Codification
	<p>SECTION 1. SHORT TITLE. This Act may be cited as the “Helping Ensure Life and Limb-Saving Access to Podiatric Physicians Act” or the “HELLPP Act”.</p>	
<p>§ 1905(a)(5)(A), Social Security Act <i>[42 U.S.C. 1396d]</i> For purposes of this title —</p> <p>(a) The term “medical assistance” means payment of part or of all of the following care and services ...</p> <p>(5) (A) physicians’ services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient’s home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist ...</p> <p><i>[Statutory Note and Reference — Sec. 1861(r)(1) of the Social Security Act defines the term “physician” under the Medicare program as including: “a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action ...”]</i></p>	<p>SEC. 2. RECOGNIZING DOCTORS OF PODIATRIC MEDICINE AS PHYSICIANS UNDER THE MEDICAID PROGRAM.</p> <p>(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking “section 1861(r)(1)” and inserting “paragraphs (1) and (3) of section 1861(r)”.</p> <p><i>[Statutory Note and Reference — Sec. 1861(r)(3) of the Social Security Act further defines the term “physician” under the Medicare program as including: “a doctor of podiatric medicine ...”]</i></p> <p>(b) EFFECTIVE DATE.—</p> <p>(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to services furnished on or after</p>	<p><i>[42 U.S.C. 1396d]</i></p> <p>(a) The term “medical assistance” means payment of part or of all of the following care and services ...</p> <p>(5) (A) physicians’ services furnished by a physician (as defined in paragraphs (1) and (3) of section 1861(r) section 1861(r)(1)), whether furnished in the office, the patient’s home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist ...</p>

Side by Side Comparison of Current Law vs. HELLPP Act (HR 1221 / S 626)

Current Law	HR 1221 / S 626	Codification
	<p>January 1, 2016.</p> <p>(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.</p>	
<p>§ 1861(s)(12), Social Security Act <i>[42 U.S.C. 1395x]</i></p> <p>(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987^[515], extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—</p>	<p>SEC. 3. CLARIFYING MEDICARE DOCUMENTATION REQUIREMENTS FOR THERAPEUTIC SHOES FOR PERSONS WITH DIABETES.</p> <p>(a) IN GENERAL.—Section 1861(s)(12) of the Social Security Act (42 U.S.C. 1395x(s)(12)) is amended to read as follows:</p> <p>(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts (in this paragraph referred to as ‘therapeutic</p>	<p><i>[42 U.S.C. 1395x]</i></p> <p>(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987^[515], extra-depth shoes with inserts or custom molded shoes with inserts (in this paragraph referred to as ‘therapeutic shoes’) for an individual with</p>

Side by Side Comparison of Current Law vs. HELLPP Act (HR 1221 / S 626)

Current Law	HR 1221 / S 626	Codification
<p>(A) the physician who is managing the individual's diabetic condition —</p> <p style="padding-left: 40px;">(i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and</p> <p style="padding-left: 40px;">(ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;</p> <p>(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and</p>	<p>shoes') for an individual with diabetes, if —</p> <p>(A) the physician who is managing the individual's diabetic condition —</p> <p style="padding-left: 40px;">(i) documents that the individual has diabetes;</p> <p style="padding-left: 40px;">(ii) certifies that the individual is under a comprehensive plan of care related to the individual's diabetic condition; and</p> <p style="padding-left: 40px;">(iii) documents agreement with the prescribing podiatrist or other qualified physician (as established by the Secretary) that it is medically necessary for the individual to have such extra-depth shoes with inserts or custom molded shoes with inserts;</p> <p>(B) the therapeutic shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary) who—</p> <p style="padding-left: 40px;">(i) examines the individual and determines the medical necessity for the individual to receive the therapeutic shoes; and</p> <p style="padding-left: 40px;">(ii) communicates in writing the medical necessity to a certifying doctor of medicine or osteopathy for the individual to have therapeutic shoes along with findings that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-</p>	<p>diabetes, if —</p> <p>(A) the physician who is managing the individual's diabetic condition —</p> <p style="padding-left: 40px;">(i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and diabetes;</p> <p style="padding-left: 40px;">(ii) certifies that the individual is needs needs such shoes under a comprehensive plan of care related to the individual's diabetic condition, and</p> <p style="padding-left: 40px;">(iii) documents agreement with the prescribing podiatrist or other qualified physician (as established by the Secretary) that it is medically necessary for the individual to have such extra-depth shoes with inserts or custom molded shoes with inserts;</p> <p>(B) the particular type of therapeutic shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and who—</p> <p style="padding-left: 40px;">(i) examines the individual and determines the medical necessity for the individual to receive the therapeutic shoes; and</p> <p style="padding-left: 40px;">(ii) communicates in writing the medical necessity to a certifying doctor of medicine or osteopathy for the individual to have therapeutic shoes along with findings that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-</p>

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Current Law	HR 1221 / S 626	Codification
<p>(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);</p>	<p>ulcerative calluses, a history of previous ulceration, foot deformity, previous amputation, or poor circulation (or any combination thereof); and</p> <p>(C) the therapeutic shoes are fitted and furnished by a podiatrist or other qualified supplier individual (as established by the Secretary), such as a pedorthist or orthotist, who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);”.</p> <p>(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 2016.</p> <p>(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding Medicare coverage for therapeutic shoes for individuals with diabetes.</p>	<p>ulcerative calluses, a history of previous ulceration, foot deformity, previous amputation, or poor circulation (or any combination thereof); and</p> <p>(C) the therapeutic shoes are fitted and furnished by a podiatrist or other qualified supplier individual (as established by the Secretary), such as a pedorthist or orthotist, as established by the Secretary who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);</p>

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Current Law	HR 1221 / S 626	Codification
<p>26 U.S.C. § 6331 — LEVY AND DISTRAINT</p> <p>(h) Continuing levy on certain payments</p> <p>(1) In general If the Secretary approves a levy under this subsection, the effect of such levy on specified payments to or received by a taxpayer shall be continuous from the date such levy is first made until such levy is released. Notwithstanding section 6334, such continuous levy shall attach to up to 15 percent of any specified payment due to the taxpayer.</p> <p>(2) Specified payment For the purposes of paragraph (1), the term “specified payment” means—</p> <p>(A) any Federal payment other than a payment for which eligibility is based on the income or assets (or both) of a payee,</p> <p>(B) any payment described in paragraph (4), (7), (9), or (11) of section 6334 (a), and</p> <p>(C) any annuity or pension payment under the Railroad Retirement Act or benefit under the Railroad Unemployment Insurance Act.</p> <p>(3) Increase in levy for certain payments Paragraph (1) shall be applied by substituting “100 percent” for “15 percent” in the case of any specified payment due to a vendor of</p>	<p>SEC. 4. BUDGET SAVINGS: STRENGTHENING MEDICAID PROGRAM INTEGRITY THROUGH CONTINUOUS LEVY ON PAYMENTS TO MEDICAID PROVIDERS AND SUPPLIERS.</p> <p>(a) IN GENERAL.—Section 6331(h)(2) of the Internal Revenue Code of 1986 (defining specified payment) is amended by striking “and” at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting “, and”,</p> <p>and by adding at the end the following new subparagraph: “(D) any payment to any medicaid provider or supplier under a State plan under title XIX of the Social Security Act.”.</p>	<p>26 U.S.C. § 6331 — LEVY AND DISTRAINT</p> <p>(h) Continuing levy on certain payments</p> <p>(1) In general If the Secretary approves a levy under this subsection, the effect of such levy on specified payments to or received by a taxpayer shall be continuous from the date such levy is first made until such levy is released. Notwithstanding section 6334, such continuous levy shall attach to up to 15 percent of any specified payment due to the taxpayer.</p> <p>(2) Specified payment For the purposes of paragraph (1), the term “specified payment” means—</p> <p>(A) any Federal payment other than a payment for which eligibility is based on the income or assets (or both) of a payee,</p> <p>(B) any payment described in paragraph (4), (7), (9), or (11) of section 6334 (a), and</p> <p>(C) any annuity or pension payment under the Railroad Retirement Act or benefit under the Railroad Unemployment Insurance Act- , and,</p> <p>(D) any payment to any medicaid provider or supplier under a State plan under title XIX of the Social Security Act.</p> <p>(3) Increase in levy for certain payments Paragraph (1) shall be applied by substituting “100 percent” for “15 percent” in the case of any specified payment due to a vendor of</p>

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Current Law	HR 1221 / S 626	Codification
property, goods, or services sold or leased to the Federal Government.	(b) EFFECTIVE DATE.—The amendments made by this section shall apply to levies issued after the date of the enactment of this Act.	property, goods, or services sold or leased to the Federal Government.

114TH CONGRESS
1ST SESSION

H. R. 1221

To amend title XIX of the Social Security Act to cover physician services delivered by podiatric physicians to ensure access by Medicaid beneficiaries to appropriate quality foot and ankle care, to amend title XVIII of such Act to modify the requirements for diabetic shoes to be included under Medicare, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 2015

Mrs. ELLMERS of North Carolina (for herself, Ms. DEGETTE, and Mr. WENSTRUP) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XIX of the Social Security Act to cover physician services delivered by podiatric physicians to ensure access by Medicaid beneficiaries to appropriate quality foot and ankle care, to amend title XVIII of such Act to modify the requirements for diabetic shoes to be included under Medicare, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Helping Ensure Life-
3 and Limb-Saving Access to Podiatric Physicians Act” or
4 the “HELLPP Act”.

5 **SEC. 2. RECOGNIZING DOCTORS OF PODIATRIC MEDICINE**

6 **AS PHYSICIANS UNDER THE MEDICAID PRO-**
7 **GRAM.**

8 (a) IN GENERAL.—Section 1905(a)(5)(A) of the So-
9 cial Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended
10 by striking “section 1861(r)(1)” and inserting “para-
11 graphs (1) and (3) of section 1861(r)”.

12 (b) EFFECTIVE DATE.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the amendment made by subsection (a)
15 shall apply to services furnished on or after January
16 1, 2016.

17 (2) EXTENSION OF EFFECTIVE DATE FOR
18 STATE LAW AMENDMENT.—In the case of a State
19 plan under title XIX of the Social Security Act (42
20 U.S.C. 1396 et seq.) which the Secretary of Health
21 and Human Services determines requires State legis-
22 lation in order for the plan to meet the additional
23 requirement imposed by the amendment made by
24 subsection (a), the State plan shall not be regarded
25 as failing to comply with the requirements of such
26 title solely on the basis of its failure to meet these

1 additional requirements before the first day of the
2 first calendar quarter beginning after the close of
3 the first regular session of the State legislature that
4 begins after the date of enactment of this Act. For
5 purposes of the previous sentence, in the case of a
6 State that has a 2-year legislative session, each year
7 of the session is considered to be a separate regular
8 session of the State legislature.

9 **SEC. 3. CLARIFYING MEDICARE DOCUMENTATION RE-**
10 **QUIREMENTS FOR THERAPEUTIC SHOES FOR**
11 **PERSONS WITH DIABETES.**

12 (a) IN GENERAL.—Section 1861(s)(12) of the Social
13 Security Act (42 U.S.C. 1395x(s)(12)) is amended to read
14 as follows:

15 “(12) subject to section 4072(e) of the Omni-
16 bus Budget Reconciliation Act of 1987, extra-depth
17 shoes with inserts or custom molded shoes with in-
18 serts (in this paragraph referred to as ‘therapeutic
19 shoes’) for an individual with diabetes, if—

20 “(A) the physician who is managing the in-
21 dividual’s diabetic condition—

22 “(i) documents that the individual has
23 diabetes;

1 “(ii) certifies that the individual is
2 under a comprehensive plan of care related
3 to the individual’s diabetic condition; and

4 “(iii) documents agreement with the
5 prescribing podiatrist or other qualified
6 physician (as established by the Secretary)
7 that it is medically necessary for the indi-
8 vidual to have therapeutic shoes;

9 “(B) the therapeutic shoes are prescribed
10 by a podiatrist or other qualified physician (as
11 established by the Secretary) who—

12 “(i) examines the individual and de-
13 termines the medical necessity for the indi-
14 vidual to receive the therapeutic shoes; and

15 “(ii) communicates in writing the
16 medical necessity to a certifying doctor of
17 medicine or osteopathy for the individual
18 to have therapeutic shoes along with find-
19 ings that the individual has peripheral neu-
20 ropathy with evidence of callus formation,
21 a history of pre-ulcerative calluses, a his-
22 tory of previous ulceration, foot deformity,
23 previous amputation, or poor circulation;
24 and

1 “(C) the therapeutic shoes are fitted and
 2 furnished by a podiatrist or other qualified sup-
 3 plier individual (as established by the Sec-
 4 retary), such as a pedorthist or orthotist, who
 5 is not the physician described in subparagraph
 6 (A) (unless the Secretary finds that the physi-
 7 cian is the only such qualified individual in the
 8 area);”.

9 (b) EFFECTIVE DATE.—The amendment made by
 10 subsection (a) shall apply with respect to items and serv-
 11 ices furnished on or after January 1, 2016.

12 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
 13 tion shall be construed as expanding Medicare coverage
 14 for therapeutic shoes for individuals with diabetes.

15 **SEC. 4. BUDGET SAVINGS: STRENGTHENING MEDICAID**
 16 **PROGRAM INTEGRITY THROUGH CONTIN-**
 17 **UOUS LEVY ON PAYMENTS TO MEDICAID**
 18 **PROVIDERS AND SUPPLIERS.**

19 (a) IN GENERAL.—Section 6331(h)(2) of the Inter-
 20 nal Revenue Code of 1986 (defining specified payment)
 21 is amended by striking “and” at the end of subparagraph
 22 (B), by striking the period at the end of subparagraph
 23 (C) and inserting “, and”, and by adding at the end the
 24 following new subparagraph:

1 “(D) any payment to any Medicaid pro-
2 vider or supplier under a State plan under title
3 XIX of the Social Security Act.”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to levies issued after the date of
6 the enactment of this Act.

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