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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515-6115

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MEMORANDUM

July 18, 2017

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Examining Bipartisan Legislation to Improve the Medicare Program"

On **Thursday, July 20, 2017, at 10:00 a.m. in room 2123 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing titled "Examining Bipartisan Legislation to Improve the Medicare Program." The hearing will focus on a number of bipartisan bills that make changes to the Medicare program, particularly Medicare Part B, which covers physician services, outpatient services, laboratory services, durable medical equipment, and some home health services.

I. H.R. ___, TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO EXTEND THE THERAPY CAP EXCEPTIONS PROCESS AND MANUAL MEDICAL REVIEW UNDER THE MEDICARE PROGRAM

Medicare covers medically necessary outpatient physical and occupational therapy (PT and OT) services, and speech-language pathology (SLP) services. Under the Balanced Budget Act of 1997 (BBA), Congress placed an annual cap on reimbursement for rehabilitation therapy services. For 2017, the therapy cap is set at $1,980 for PT and SLP combined, and $1,980 for OT services. Medically necessary therapy claims can exceed the cap, subject to an "exceptions" process. Once a beneficiary's incurred expenses exceed $3,700 for PT and SLP combined or $3,700 for OT, reimbursement is subject to manual medical review (MMR). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the exceptions process through December 31, 2017, eliminated the requirement for MMR of all claims exceeding the $3,700 threshold, and put in place a targeted medical review process. The draft bill would extend the exceptions process and provide funding for targeted medical review.

II. H.R. 1148, FURTHERING ACCESS TO STROKE TELEMEDICINE (FAST) ACT OF 2017

H.R. 1148, introduced by Rep. Griffith (R-VA) and Rep. Beatty (D-OH), would provide Medicare reimbursement for stroke telemedicine services (also known as telestroke) regardless of the patient originating site, and waive the originating site facility fee. Under current law, Medicare only covers telestroke services provided at rural originating sites. Stroke telemedicine refers to a telemedicine service that connects stroke patients to a team of providers, usually including a neurologist and a nurse, for the diagnosis and treatment of stroke. Telestroke can be an important service to patients who cannot quickly access a stroke specialist.

III. H.R. ___, MOBILE LABS

H.R. ___, a discussion draft pertaining to mobile labs, would create a bundled payment for clinical lab services provided to nursing facilities and homebound patients. Currently, mobile labs are reimbursed separately for appropriate personnel and travel costs for sending trained personnel to a beneficiary to collect a sample, in addition to reimbursement under Medicare for the test itself. The draft bill would create a bundled payment that would establish a per episode payment for clinical laboratory services provided to nursing facility and homebound patients. The objectives of the draft bill are to maintain beneficiary access to this important benefit, improve program integrity, and reduce compliance costs associated with documentation under the current reimbursement system.

IV. H.R. 849, PROTECTING SENIORS' ACCESS TO MEDICARE ACT OF 2017

H.R. 849, introduced by Rep. Roe (R-TN) and Rep. Ruiz (D-CA), would repeal the Independent Payment Advisory Board (IPAB). As established under the Affordable Care Act (ACA), the IPAB is comprised of 15 Presidentially-appointed and Senate-confirmed individuals. The board is tasked with submitting binding recommendations to Congress to reduce the rate of growth in Medicare spending per beneficiary. IPAB has not been convened to date.

Each year, the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) must determine whether the projected five-year average Medicare growth rate will exceed the target growth rate. If the Actuary finds that the growth rate exceeds the target, the Actuary is required to establish an applicable savings target. The board is then required to submit recommendations to Congress to achieve these savings. IPAB's recommendations may not involve rationing care, reducing benefits or increasing cost sharing, premiums or taxes. The Committees of jurisdiction and the full House or full Senate can modify IPAB's recommendations, as long as the same level of reductions in Medicare spending growth are achieved. For 2017, as with each year since IPAB went into effect in 2013, the CMS Chief Actuary concluded that the target growth rate will not be exceeded.[1] As a result, the IPAB recommendation process was not triggered this year.

[1] Letter from Paul Spitalnic, Chief Actuary, Centers for Medicare & Medicaid Services to Administrator Verma (July 13, 2017).

V. H.R. 3120, TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO REDUCE THE VOLUME OF FUTURE ELECTRONIC HEALTH RECORD-RELATED SIGNIFICANT HARDSHIP REQUESTS

H.R. 3120, introduced by Representatives Burgess (R-TX) and Dingell (D-MI), would amend the Health Information Technology for Economic and Clinical Health (HITECH) Act requirement on the Secretary to impose "more stringent measures of meaningful use" over time. The bill's objective is to reduce the number of providers needing to seek hardship exemptions from the requirements of the meaningful use program, thus enabling more providers to remain in the program. The Secretary must still "seek to improve the use of electronic health records and health care quality over time."

VI. H.R. 3163, MEDICARE PART B HOME INFUSION SERVICES TEMPORARY TRANSITIONAL PAYMENT ACT

H.R. 3163, introduced by Representatives Tiberi (R-OH) and Pascrell (D-NJ), provides a temporary transitional payment for home infusion therapy under the Medicare program. Home infusion therapy refers to the administration of a parenteral or biological drug administered intravenously or subcutaneously through a durable medical equipment (DME) pump in a patient's home. In the past, CMS overpaid for home infusion services. A 2013 Office of Inspector General (OIG) report found that Medicare was paying anywhere from 54 to 122 percent more than the average sales price for home infusion drugs. The overpayment problem was addressed in the 21st Century Cures legislation by lowering the payment for home infusion drugs to the average sales price plus 6 percent, while adding in a payment for services associated with the administration of home infusion. The reduced payment for home infusion drugs became effective as of January 1, 2017, but the services payment will not begin until 2021, thus raising the possibility of reduced patient access to home infusion drugs. This bill provides a temporary bridge payment beginning in 2019 through 2021, when the services benefit is expected to begin.

VII. H.R. 3245, MEDICARE CIVIL AND CRIMINAL PENALTIES UPDATE ACT

H.R. 3245, introduced by Representatives Bilirakis (R-FL) and Castor (D-FL), would update civil and criminal penalties for committing fraud against a federal health care program. It would, for example, increase both civil monetary penalties and maximum criminal penalties for presenting false claims to the federal government, providing medical items or services known to be not medically necessary, or practicing without an appropriate license.

VIII. H.R. 3271, PROTECTING ACCESS TO DIABETES SUPPLIES ACT OF 2017

H.R. 3271, introduced by Representatives DeGette (D-CO) and Brooks (R-IN), would makes changes to Medicare's competitive bidding program for diabetic testing strips. The bill would require CMS to provide stronger assurances that suppliers provide at least 50 percent of all types of diabetes test supplies available on the market before implementation of the competitive bidding program. The bill would also codify a regulatory provision preventing suppliers from coercing beneficiaries into changing their choice of testing strips. Similarly, it would make it easier for beneficiaries to switch to and receive different testing supplies.

IX. H.R. 2465, THE STEVE GLEASON ENDURING VOICES ACT

H.R. 2465, introduced by Representatives McMorris Rodgers (R-WA) and Doyle (D-PA), would permanently remove the DME rental cap for speech generating devices (SGDs). SGDs are used for individuals with communications disabilities, such as Amyotrophic Lateral Sclerosis (ALS). In 2015, Congress passed and former President Obama signed the Steve Gleason Act of 2015, which removed SGDs from the capped rental category until October 1, 2018. H.R. 2465 would make this policy permanent.

CMS decided in 2015, to cover SGDs via a capped rental payment. Certain DME items are subject to a rental cap, by which a beneficiary rents a DME item for 13 (continuous) months, after which the supplier transfers title of the item to the individual. Under the capped rental, Medicare payment for SGD stopped during periods of institutionalization, therefore limiting beneficiary access to the SGD while in a nursing home, hospital or hospice.

X. H.R. 2557, THE PROSTATE CANCER MISDIAGNOSIS ELIMINATION ACT

H.R. 2557, introduced by Representatives Bucshon (R-IN) and Rush (D-IL), would provide coverage under the Medicare program of a DNA Specimen Provenance Assay clinical diagnostic laboratory test (DSPA test). The DSPA test is a DNA test that would match the biopsied tissue to the individual being tested, ensuring that provenance errors do not result in an erroneous positive result and potentially costly and unnecessary medical treatment. Medical literature indicates that false positives for prostate cancer diagnosis are approximately 1.3 percent, due to errors made in the collection, transport, and processing of specimens from biopsies. The objective of the bill is to reduce the number of individuals who receive an erroneous positive diagnosis for prostate cancer, and therefore receive unnecessary treatment.

XI. H.R. 3263, EXTENSION OF THE INDEPENDENCE AT HOME DEMONSTRATION

H.R. 3263, introduced by Representatives Burgess (R-TX), Dingell (D-MI), Roskam (R-IL) and Thompson (D-CA), would extend the Medicare Independence at Home (IAH) Demonstration Project for two additional years. The legislation would also increase the number of beneficiaries participating in the demonstration from 10,000 to 15,000 and allow for participating medical practices to demonstrate savings and receive incentive payments within three years (instead of two years under current law). IAH began as a three year demonstration program in 2012. It was later extended for two years under the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015. The demonstration allows seniors with multiple, advanced and often expensive chronic conditions to receive home based primary care from a team of providers. Home based treatment removes access to care barriers for seniors and allows for seniors to be treated in a setting where they are most comfortable. The program rewards providers that deliver quality care while reducing costs. CMS estimates that IAH saved $25 million in the first performance year and more than $10 million in the second performance year. Analysis of the demonstration also found that participants had fewer hospital readmissions, better medication management and care planning, and improved follow up.

XII. WITNESSES

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