The Honorable Glenn "GT" Thompson (PA-15)
Testimony before the House Committee on Energy and Commerce
Member Day Hearing on Priorities in the 118th Congress
September 19, 2023

Chair Rodgers, Ranking Member Pallone, and Members of the House Committee on Energy and Commerce:

Good morning and thank you for providing the opportunity to share my priorities for the 118th Congress. Representing one of the most rural districts east of the Mississippi River, accessible and affordable health care is a top priority for me and my constituents who too often face unnecessary barriers to accessing the care they need. After spending nearly three decades as a therapist, rehabilitation services manager, and licensed nursing home administrator prior to coming to Congress, I have seen firsthand the importance of access to quality health care in rural communities. Today, I would like to discuss several pieces of legislation before this Committee that remove some of these obstacles and increase access, affordability, and quality of care for patients across the country.

Medicare Orthotics and Prosthetics Patient-Centered Care Act

H.R. 4315, the *Medicare Orthotics and Prosthetics Patient-Centered Care Act,* would strengthen Medicare for beneficiaries who use orthoses and prostheses by reducing waste, fraud, and abuse within the Medicare program and expanding access to these critical devices. Orthoses (orthopedic braces) and protheses (artificial limbs) help millions of Americans increase mobility, recover from injury, and improve overall quality of life.

Medicare currently reimburses the "drop shipment" of custom orthoses and prostheses directly to a Medicare beneficiary's home without any clinical guidance, training, or intervention from a provider or supplier. This leads to rampant waste, fraud, and abuse within Medicare as durable medical equipment suppliers are reimbursed for devices that may not fit a patient's needs, do not work as advertised, or are not able to be operated without professional guidance. This legislation prohibits the drop-shipment of all prosthetic limbs and custom-fabricated or custom-fitted orthoses, potentially saving Medicare billions and ensuring these beneficiaries have appropriate access to a health care practitioner to provide the necessary guidance for proper use of their device.

H.R. 4315 also expands access to replacement orthoses for Medicare beneficiaries. Currently, Medicare does not generally cover the replacement of a custom-fitted or custom-fabricated orthosis within the "reasonable use lifetime" of the orthosis, usually around five years. This forces beneficiaries to wait long periods of time before being eligible for replacements, undeniably delaying access to medically necessary care. The bill would allow Medicare to reimburse for a replacement orthosis if any of the following conditions are met:

- A change in the physiological condition of the patient

- An unrepairable change in the condition of the orthosis
- The orthosis requires repairs and those costs would be more than 60 percent of the cost to replace the orthosis

Finally, this legislation also implements a zero-cost regulatory fix to allow certified or licensed orthotists and prosthetists to provide off-the-shelf orthoses directly to Medicare beneficiaries by exempting them from competitive bidding. Under the present system, orthotists and prosthetists without a competitive bidding license are required to send patients in need of an off-the-shelf orthosis to a colleague that has a competitive bidding license, adding an unnecessary barrier to care. This change brings orthotists and prosthetists in line with other providers, like physical and occupational therapists and physicians, who the Centers for Medicare and Medicaid Services (CMS) also exempt from the competitive bidding process.

I respectfully urge the Committee to provide for consideration of the *Medicare Orthotics and Prosthetics Patient-Centered Care Act* to reduce waste in Medicare and increase access to these devices for patients across the country.

Improving Access to Medicare Coverage Act

As you may know, current Medicare law requires that patients have an inpatient stay of at least three days in order for Medicare to pay for prescribed care at a skilled nursing facility (SNF). There is mounting concern and evidence that too many Medicare beneficiaries and their families are being saddled with insurmountable, surprise out-of-pocket costs for stays at SNFs because hospitals are increasingly caring for these patients under "outpatient observation status" rather than admitting them as inpatients. This billing technicality has significant repercussions for beneficiaries who are left facing either enormous, unexpected post hospital bills or avoiding the care and treatment their doctors have suggested.

In 2013, both the HHS Office of the Inspector General and the Long Term Care Commission urged the CMS to consider ways "to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services," including the request to count time spent in observation status toward meeting CMS' three day stay requirement. We saw the temporary waiver of the three-day rule during the COVID-19 pandemic, and now it is time to take it a step further.

H.R. 5138, the *Improving Access to Medicare Coverage Act*, is bipartisan legislation that ensures Medicare covers this doctor-recommended post-acute care by counting the time spent under "observation status" toward the requisite three-day hospital stay for coverage of skilled nursing care. Medicare beneficiaries should be able to have peace of mind when receiving medical care advised by their physicians and certainty that Medicare will reimburse their care.

Therefore, I respectfully request the Committee give full and fair consideration to H.R. 5138 and help expand access to necessary medical care for Medicare beneficiaries.

Telehealth

As a former health care professional, I am amazed at how telehealth services make life simpler for rural and underserved communities. During the COVID-19 Public Health Emergency, we have seen the use of telehealth increase dramatically. Health care providers, including federally qualified health centers (FQHC) and rural health clinics (RHC), have adopted telehealth to safely provide care to individuals throughout the country. These services include routine health care like wellness visits, medication consultation, dermatology, eye exams, nutrition counseling, and mental health counseling.

The pandemic has laid bare the critical and immediate need for expanded access to telehealth and telemedicine services throughout the country. The ability to use telehealth services during this crisis has demonstrated how this technology can play a pivotal role in improving health equity by increasing access to care for vulnerable populations, particularly those in rural communities who face unique barriers.

In the near future, I will reintroduce the *Helping Ensure Access to Local TeleHealth (HEALTH) Act*, bipartisan legislation that builds off provisions in previously passed COVID-19 packages that waived telehealth restrictions and encouraged the use of telehealth to provide access to care. This legislation would permanently allow FQHCs and RHCs the ability to provide telehealth services as "distant sites" under Medicare. Medicare will reimburse these facilities the same as if an individual received services at the physical brick-and-mortar location. The bill also allows these health facilities to continue to utilize audio-only telehealth visits for patients who do not have access to quality broadband.

Continued use and promotion of telehealth will improve health equity by increasing access to care for our most vulnerable. The *HEALTH Act* will cut red tape and permanently allow community health centers and RHCs to furnish telehealth services to their patients. Once introduced, I request the Committee give this bill full and fair consideration.

Inpatient Rehabilitation Therapy

CMS uses an intensity of therapy requirement to determine, in part, which Medicare beneficiaries qualify for treatment in an inpatient rehabilitation facility (IRF). The "Three-Hour Rule" requires the patient to participate in, and benefit from, at least three hours of rehabilitation therapy per day, five days per week. Prior to 2010, CMS regulations for IRFs explicitly recognized physical therapy, occupational therapy, speech therapy, and/or orthotics and prosthetics as countable toward the "Three-Hour Rule" but allowed the physician and rehabilitation team to prescribe the appropriate mix of "other therapeutic modalities" in addition to the skilled services listed in the regulation. In 2010, CMS revised the IRF regulations and limited the "Three-Hour Rule," removing the physician's discretion to count additional therapeutic services toward satisfaction of the rule. Other skilled therapies, including recreational therapy, psychological services, respiratory therapy, and neuropsychological services, are no longer counted.

Although IRFs are permitted to provide these services, the fact that they cannot be counted toward the rule has limited their availability in many rehabilitation hospitals. During the COVID-19 Public Health Emergency, the "Three-Hour Rule" was waived in its entirety. Despite this broad flexibility, nationwide IRF data demonstrates that admissions did not increase, and the average amount of therapy provided to patients remained steady. The blanket waiver of the rule has not resulted in negative impacts on care, but has allowed IRF patients to receive a broader, more appropriate mix of therapies to treat their conditions.

In the near future, I will reintroduce the *Access to Inpatient Rehabilitation Therapy Act* to ensure that rehabilitation physicians are able to prescribe the correct mix of skilled rehabilitation therapies for their patients by allowing "other skilled therapeutic modalities," including recreational therapy, respiratory therapy, and other defined by CMS, to count toward the intensity of therapy requirement during an IRF stay. This bipartisan legislation will support America's seniors by preserving expanded access to skilled rehabilitation therapies for Medicare patients. As a former rehabilitation therapist, I request the Committee give full and fair consideration to the bill once introduced.

Thank you again to Chair Rodgers, Ranking Member Pallone, and Members of this Committee for allowing me to express my priorities for this Committee in the 118th Congress. I appreciate your consideration and look forward to working together on these and other issues.