RPTR SCOTT

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EXAMINING POTENTIAL WAYS TO IMPROVE THE MEDICARE PROGRAM

THURSDAY, OCTOBER 1, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Burgess, Lance, Griffith, Bilirakis, Elmers, Bucshon, Brooks, Collins, Green, Schakowsky, Butterfield, Castor, Matsui, Lujan, Schrader, Kennedy, and Pallone (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Rebecca Card, Staff Assistant, Noelle Clemente, Press Secretary, Graham Pittman, Legislative Clerk, Heidi Stirrup, Health Policy Coordinator,

Christine Brennan, Minority Press Secretary, Jeff Carroll, Minority Staff Director, Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor, Ashley Jones, Minority Director of Communications, Member Services and Outreach, Samantha Satchell, Minority Policy Analyst, Matt Schumacher, Minority Press Assistant, and Arielle Woronoff, Minority Health Counsel.

Mr. Pitts. It is 10 o'clock, so we will begin.

The subcommittee will come to order.

The Chair will recognize himself for an opening statement. Today's hearing, will consider three bipartisan legislative bills designed to strengthen the Medicare program:

H.R. 556, the Prevent Interruptions in Physical Therapy Act, sponsored by our colleague Representative Gus Bilirakis of Florida, would add therapists -- physical, occupational, and speech -- to the list of providers allowed to transfer care for a Medicare patient in circumstances of illness, pregnancy, or vacation;

H.R. 1934, the Cancer Care Payment Reform Act, sponsored by the House Republican Conference chairman, Cathy McMorris Rodgers of Washington, establishes a national Oncology Medical Home Demonstration Project to improve Medicare payments for cancer care;

Thirdly, draft legislation, authored by Representative Greg Walden of Oregon, would make changes to documentation and face-to-face requirements for home health providers under the Medicare program.

Together, these three bills continue the commitment this Congress has to strengthen the Medicare program and to keep the promise for seniors, which was started earlier this year by permanently repealing and replacing the broken sustainable growth rate, the SGR, an effort spanning several years to enactment this past April.

I want to thank our witnesses for agreeing to testify today. They bring real world experience regarding problems in the Medicare program, and we welcome their views on the legislation before us today.

And I will yield to any of my colleagues on my side of the aisle if they would like to make any statements. None?

All right. I yield back.

I recognize Mr. Lujan of New Mexico for 5 minutes for his opening statement.

[The prepared statement of Mr. Pitts follows:]

******** COMMITTEE INSERT ********

Mr. Lujan. Thank you very much, Chairman Pitts. And I appreciate you and the ranking member and all the members of the subcommittee for allowing us to be here today for this important conversation.

I am pleased that, today, the committee is considering H.R. 556, the Prevent Interruptions to Physical Therapy Act. Physical therapy.

Congressman Bilirakis and I introduced this bill in the previous Congress and again at the beginning of this Congress because, under current law, physical therapists are not allowed to enter locum tenens agreements. The physical therapy act changes this by allowing physical therapy practices to hire a qualified locum tenens physical therapist to treat Medicare patients during an absence by one of the practice's regular physical therapists.

For many seniors, physical therapy services provide a path to restore mobility after an injury or a medical procedure and a way to restore function and return to the activity level that they have long enjoyed. With the help of their physical therapists many patients are able to recover and continue to live independently with a higher quality of life.

There are times, however, when physical therapy services can be interrupted due to the provider having an illness, taking a vacation, maternity leave, or continuing their professional education. In other words, Mr. Chairman, you know, life moves on as well; but, unfortunately, physical therapists aren't able to try to bring in some of their peers to provide coverage, like doctors, osteopathic

physicians, dental surgeons, podiatrists, optometrists, or chiropractors.

These interruptions can easily be handled by entering into what is called a locum tenens agreement with another qualified provider. Under these arrangements, the regular provider is able to bill and receive payment under Medicare part B for the locum tenens provider services as if they had performed them themselves. The locum tenens provider is compensated directly by the practice of the regular provider.

These arrangements are common and extremely beneficial to patients and providers alike as the relationship between the patient and the practice is continued by another licensed, qualified provider during their short-term leave. Especially in isolated rural areas, a locum tenens provider can keep a small medical practice open to serve patients who would otherwise have to travel long distances to another provider. By hiring a locum tenens, a provider is able to ensure that their patient care does not lapse.

The Senate companion bill was voted out of committee in June, and I am pleased that our bill is before the committee today; and I look forward to the testimony and questions about this commonsense legislation.

And, again, I want to thank Congressman Bilirakis for his leadership. It has been a pleasure and an honor to work with him on this important issue.

With that, Mr. Chairman, I yield back.

[The prepared statement of Mr. Lujan follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. The Chair thanks the gentleman.

In lieu of the chairman, the Chair recognizes Mr. Bilirakis of Florida for 5 minutes for an opening statement.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate is very much. Thanks for also addressing this particular bill, this morning. The Prevent Interruptions in Physical Therapy Act is a bipartisan bill that I introduced, along with my good friend and colleague, Ben Ray Lujan.

Currently, Medicare allows a wide range of medical providers, including doctors of medicine, osteopathy, and chiropractors, the ability to bring in other licensed professionals under their provider number. This allows for substitutes for when a practice is short-staffed for a short period of time for reasons such as illness, maternity or paternity leave, or vacation. Such instances are referred to as "locum tenens arrangements." Physical therapists currently are excluded from employing locum tenens in their practices, forcing seniors to either find a new physical therapist or not receive treatment during the time their therapist is out.

To illustrate the problem that occurs, this is a letter from Alicia Nixon, a physical therapist in Hillsborough County, Florida, and I quote: "I am a private practice owner and have served mostly Medicare patients for the last 11 years. The current Medicare rules have been very difficult and detrimental, at times, to my practice's liability. Just as important, there has been times that were completely unavoidable and that the Medicare patients were not able

to be seen in order to remain in compliance with the current regulations. It has been almost impossible to take a vacation or time to attend conferences or seminars because of my need to be on site at the clinic. I was recommended to have surgery 6 years ago that I still have not had because it would require me to be away from the practice for over 6 weeks for recovery. When I received a court summons, I had to close the clinic for 2 days with patient visits having to be canceled, and all staff lost wages from the necessary closure" end quote.

At one point, this practice lost a physical therapist. It took about a year to fill that vacancy, and then she writes again and I quote: "In the timeframe that I was looking to fill the vacancy here at the practice, my biggest fear was that, if I was in an accident and physically not able to be on site for a period of time, it would mean certain closure of the office. It is very sad that an office that has provided excellent services to the Medicare community is so vulnerable because of the current regulations." We need to pass this bill, Mr. Chairman. It is pro-patient and pro-physical therapist.

I'll yield back. Actually, I would like to yield the rest of my time to Chairman Greg Walden. Thank you.

[The prepared statement of Mr. Bilirakis follows:]

******** COMMITTEE INSERT ********

Mr. Walden. I thank the gentleman very much.

Mr. Chairman and ranking member, thank you for holding this hearing. It is a very important issue. We need to explore the problems with this face-to-face regulation.

Our Nation has made a promise to seniors who rely on Medicare, and we must keep it, and one way to keep this promise is through home health services.

So I am happy to introduce Sarah Myers, who will be sharing her knowledge about what is going on out there. She is the Executive Director of the Oregon Association of Home Health Care. Sarah has been recognized for her outstanding contribution to the Oregon home care community and has provided the Oregon delegation with a wealth of information on the critical issues facing home health providers and the patients that they serve.

In general, home health, as you know, is less expensive, more convenient, and just as effective as care in a skilled nursing facility. Receiving care at home gives seniors more control over their health care, and it provides a sense of comfort, familiarity, and normalcy for the patient and for their loved ones.

I know this firsthand because it was the choice my parents and I made, and, in Oregon, more than 20,000 Medicare beneficiaries make that same choice.

However, under current documentation requirements associated with a so-called "face-to-face requirement" have placed significant pressures on the home health care community and the people they serve.

In order for a patient to meet the eligibility criteria for home health, a physician must document that a face-to-face meeting occurred between the patient and a physician or a non patient practitioner -- or a non physician practitioner.

While intended to be a way to reduce waste, fraud, and abuse by ensuring the orders and certification of home health care are based on actual knowledge of the patient's condition, unclear documentation requirements from the government have led to a slew of payment denials and additional documentation requests.

So we have a situation in which a complicated regulatory process simply needs to be streamlined and standardized, and that is what this election would do.

First, it requires the Secretary to develop a single standardized form which satisfies the requirements of the home health certification;

And second, the bill streamlines the process and eases the requirements if the patient has been discharged from the hospital or skilled nursing facility;

Third, anyone who uses this form must receive proper notification and education on the documentation requirements;

And finally, the Secretary must implement a process to reopen review claims which were denied solely due to the face-to-face documentation concerns and issue revised decisions if the claims were denied because of the patient narrative -- a requirement that even CMS recently dropped because of the burden on providers.

So, Mr. Chairman, this isn't just about a backlog of appeals and

red tape. It is about improving access to and quality care of our seniors, and that is why this legislation has the support of the home health providers, including the Partnership for Quality Home Healthcare, the National Association for Home Care & Hospice, and the Visiting Nurse Associations of America.

Mr. Chairman, I ask unanimous consent to submit their statements for the record.

I also would like to submit into the record three letters to CMS from 2011, 2013, and 2014 from the House and Senate, expressing concerns with the face-to-face documentation request.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Walden. I thank the chairman, and I appreciate his indulgence, and your work on this legislation.

I yield back.

Mr. Pitts. The Chair thanks the gentleman.

[The prepared statement of Mr. Walden follows:]

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Mr. Pitts. And now recognizes the ranking member of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

I am always happy to come together to examine bipartisan ways to improve the Medicare program and beneficiary access, and I would be remiss in not mentioning that a witness from the administration would have made this hearing more informative. The administration would have been able to speak to whether these bills are implementable and what we could do to improve them.

The first bill under discussion today is an example of why the administration's input would help inform our decisionmaking. The bill would set up a national Oncology Medical Home Demonstration Project in the Medicare program through care coordination management fees based on performance and shared savings and arrangements with oncology practices.

We laid the foundation for these types of payment reform demonstrations in the Affordable Care Act through the establishment of accountable care organizations, medical homes, and demonstrations within the Centers for Medicare & Medicaid Innovation, CMMI.

If someone from the administration were here, they would be able to tell us about the oncology care model, a demonstration project that the Center for Medicare & Medicaid Innovation has initiated. The oncology care model would also pay coordination management fees to practices and require performance and financial accountability.

I think this type of model is worthwhile. We should absolutely

be looking at ways to improve oncology care in our country; but I am interested in learning why the legislation is necessary when CMMI is already implementing a similar model.

The second bill we are considering is H.R. 556, the Prevent Interruption in Physical Therapy Act, which would expand the locum tenens designation to include physical therapists.

Currently, Medicare allows physicians who are absent from their practices for extended periods -- for reasons such as illness, pregnancy, vacation, or continuing medical education, to retain substitute physicians to take over their practices until they return. The ability to bring in a substitute physician is called "locum tenens," and this bill would allow physical therapists to enter into these arrangements.

When there are limited options in rural or in medically underserved areas, I understand the concerns for patients' access when a physical therapist needs to be absent from his or her practice; and I look forward to working with my colleagues on this legislation to ensure it helps those who need it most.

Last, the committee is considering a discussion draft of a bill that would change the Medicare home health face-to-face requirement.

Understand that this bill is a discussion draft that has yet to be introduced, but I have concerns with further walking back the face-to-face requirement that we put in place in the Affordable Care Act.

This requirement was the result of both the inspector general and

MedPAC recommendations to route out waste and fraud in the Medicare system. CMS has been listening to industry's concerns about the requirement, and work with them to make it more streamlined and easy to comply with. In fact, over the last few years, my staff and I have advocated us for these actions; however, we must be extremely careful when removing requirements that shore up program integrity.

So, again, thank you, Mr. Chairman.

I yield the rest of my time to the ranking member, Mr. Green.

[The prepared statement of Mr. Pallone follows:]

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Mr. Green. Thank you, Mr. Chairman, and I thank our ranking member.

And I would like to ask unanimous consent that my full statement be placed in the record.

Mr. Pitts. Without objection, so ordered.

Mr. Green. I want to thank the Chair for calling this hearing today.

This marks the 50th anniversary of Medicare, and since 1965, the landmark program has provided affordable health insurance coverage and access to care for our Nation's seniors. Few programs have improved the lives of Americans as significantly as Medicare.

Today, we have three separate bills. The first is H.R. 556, the Prevent Interruptions in Physical Therapy Act.

It would allow physical therapists to employ locum tenens in their practices. Under Medicare law, health care providers are permitted to employ only licensed professionals under their provider number to care if they are temporarily unable to do so. H.R. 556 would add physical therapists to the list of providers who would enter into these agreements, known as "locum tenens agreements," so that patients do not see a disruption in care.

H.R. 1934, the Cancer Care Payment Reform Act, would establish a national Oncology Medical Home Demonstration Project. Research has shown there is a disconnect between cost and the quality of cancer care for Medicare beneficiaries, and many have suggested the fee-for-service model is inappropriate. I know, recently, the Center

for Medicare & Medicaid Innovation announced at launch a 5-year oncology care model starting next spring. The demonstration proposed in H.R. 1934 shares many of the characteristics of that Center for Medicare & Medicaid Innovation.

Mr. Chairman, like I said, I would like to ask unanimous consent for the full statement to be placed in the record.

Again, thank you for calling the hearing.

Mr. Pitts. The Chair thanks the gentleman.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. We are voting on the floor. We have 11-1/2 minutes to go, and 400 people haven't voted, so we are going to start the witnesses.

As usual, all members' written opening statements will be made a part of the record; and I'll introduce them in the order of their testimony.

First, we have Sarah Myers, CAE, Executive Director of the Oregon Association of Health Care. Welcome. Dr. Bruce Gould, President of the Community Oncology Alliance. Welcome. And Sandra Norby, PT, AT, owner, HomeTown Physical Therapy, LLC.

Thank you each for coming. Your written testimony will be made a part of the record. You will be each given 5 minutes to summarize.

Ms. Myers, you're recognized for 5 minutes.

STATEMENTS OF SARAH MYERS, CAE, OREGON ASSOCIATION OF HEALTH CARE, EXECUTIVE DIRECTOR; DR. BRUCE GOULD, COMMUNITY ONCOLOGY ALLIANCE, PRESIDENT; AND SANDRA NORBY, PT, AT, HOMETOWN PHYSICAL THERAPY, LLC, OWNER

STATEMENT OF SARAH MYERS

Ms. Myers. Chairman Pitts, Ranking Member Green, members of the subcommittee, and Congressman Walden, thank you for this opportunity to speak with you today.

My name is Sarah Myers, and I am the Executive Director of the Oregon Association for Home Care.

Our organization represents over 58 home health agencies, employing over 2,000 professionals and providing Medicare home health services to more than 30,000 Medicare beneficiaries who are homebound and many of whom are rural.

As you know, home health patients are among the most vulnerable in the Medicare program, and, in fact, Federal data shows that they are older, sicker, poorer, and more likely to be a minority and disabled than all other Medicare beneficiaries combined. Due to their frail condition, these seniors have been deemed homebound by their physicians, meaning they cannot leave their home without help or potential injury to themselves.

That is where skilled home health care providers come in.

We deliver nursing, therapy, infusion, medical social worker, and support services to patients recovering from an acute illness following a hospitalization. We also serve patients with severe disabilities that may confine them to a wheelchair or bed. Home health providers also care for patients whose disease state has advanced to the degree that their health and their mobility are now compromised, and compromises their continued ability to maintain independence without assistance.

Not only do our professional home health services meet the clinical needs of our patients in the patient preferred home setting, but they help our patients avoid being rehospitalized, and as a result, they help generate significant savings from the Medicare program and taxpayers.

Home health care is especially important to rural America. Without any access to hospitals, nursing homes, or other facilities, residents truly depend on home health. In fact, more than 630,000 Medicare beneficiaries in nearly 2,000 rural counties relied on home health services in 2013.

That is why I am here today, to speak to you and ask you to help us continue serving the frail seniors who need our care and the rural communities who depend on our delivery system.

One of the greatest burdens we face today is the implementation of the face-to-face requirement; but let me be clear: We strongly supported your action to require that no claim would be paid unless it was for services ordered by a physician as a result of the

face-to-face encounter with the patient. That is good medicine, and that is good program integrity policy.

We need to keep in mind that the physician also certifies the patient's eligibility for Medicare coverage under penalty of various anti-fraud laws. What has created the burden on physicians and home health providers is not the policy but how it has been implemented with impossible-to-meet documentation requirements that are not in the law enacted by Congress.

Inconsistencies in the lack of standardization have forced providers to chase physicians multiple times to address issues of semantics, not to improve patient care or to improve quality performance. Documentation compliance has become a moving target, resulting in countless hours of providers and physicians attempting to meet Medicare's unclear documentation rules, resulting in thousands of denied claims. Whether it is a missing signature on a completed form or an insufficient description regarding a patient's clinical condition, the implementation has resulted in a process that has, ultimately, created a paperwork mess of what should be straightforward documentation. Patient care is the priority. Burdensome paperwork and navigating red tape should not be.

What is most alarming with the documentation demands is that thousands of claims have been denied based on insufficient documentation even though a review of the full patient record reveals that the patient meets Medicare coverage criteria. This is not happening in a vacuum either. It is occurring at the same time home

health providers are struggling under an unprecedented 14 percent, 4-year cut. A cut which is pushing home health agencies to the brink.

Medicare has tried to fix the documentation nightmare. However, its efforts have fallen far short. Fortunately, there is a solution. Congressman Walden is authoring legislation that would establish a simple approach to documenting physicians' face-to-face encounters with their patients. In place of confusing requirements, physicians would simply record the date of the encounter and use a form to identify the clinical condition for which home health is needed.

We need this legislation. It will preserve your good policy while reducing unneeded paperwork and enabling us to continue serving homebound seniors in Oregon and all across America.

In closing, I want to thank Congressman Walden and all of you for your support of home health care and your dedication to America's rural communities. Your efforts mean very, very much to us. Thank you.

Mr. Pitts. The Chair thanks the gentlelady.

[The prepared statement of Ms. Myers follows:]

******** INSERT 1-1 ********

Mr. Pitts. We still have 5 minutes, and 374 Members haven't voted. We will try one more.

Dr. Gould, you're recognized for 5 minutes.

STATEMENT OF DR. BRUCE GOULD

Dr. Gould. Thank you. Chairman Pitts, Ranking Member Green, and members of the committee, I thank you for the opportunity to share my views on payment reform in oncology and specifically on the Cancer Care Payment Reform Act, H.R. 1934.

I am a practicing medical oncologist and Medical Director of Northwest Georgia Oncology Centers, a private community oncology practice headquartered in Marietta, Georgia. Additionally, I serve as President of the Community Oncology Alliance, COA, a nonprofit organization dedicated to advocating for community oncology practices and, most importantly, the patients they serve. Close to 70 percent of Americans with cancer are treated by private practice clinics. I, finally, want to mention, of relevance here, I am the son of two parents who passed away from cancer.

Community oncology practices, such as mine, have struggled from major cuts to reimbursement by Medicare. For example, the decision by CMS to apply sequestration to the underlying costs of cancer drugs has led to many drugs being reimbursed for less than their acquisition price. As a result, over 300 practices have closed treatment sites and, more significantly, close to 550 practices have merged with

hospital systems.

The data is clear on the consolidation of cancer care in the United States. It is creating access to care problems for patients in rural areas and, very significantly, increasing the costs of cancer care for seniors in the Medicare program. This unwanted trend has been documented by reports this year by the GAO and MedPAC.

Despite reimbursement pressures from Medicare, our practice, years ago, made a decision to ambitiously transform ourselves into a patient-centric Oncology Medical Home. Our goal was simple: to better control the costs of cancer care while enhancing the quality of the patient experience. Among other things, we improved care coordination for our patients, established a structured triage, initiated a comprehensive patient satisfaction survey, and developed our own treatment guidelines.

One benefit of this transformation is that same-day appointments are rarely available in our non clinics. Therefore, if our patients are ill, they can come to our clinics rather than going to the hospital emergency room. Medicare moneys are saved by the avoidance of needless emergency room visits and hospitalizations, and the patients are happier by not being subjected to hours of waiting in the emergency room.

Our hard work has recently been recognized by the commission on cancer through their accreditation of our practice as one of the first Oncology Medical Homes. Our dedication to value-based care has led us to partnering with private payors and CMS on oncology payment reform

pilots.

One program we and several others completed with UnitedHealthcare resulted in cancer care savings of 34 percent as compared to a case control group. The results were published in the peer-review "Journal of Oncology Practice," a copy of which I have submitted with my remarks for the record.

We are also part of a national $19 million grant from the Centers for Medicare & Medicaid Innovation, CMMI. The grant funded the "COME HOME" pilot, which was designed to be a real world test of the oncology and medical home tenants. Findings from NORC at the University of Chicago, the independent research entity CMMI contracted with to measure results, were nothing short of remarkable. They showed an overall reduction of cancer care costs due to reduced hospitalizations, re-admissions, and emergency department utilizations. I have included these results with my written testimony.

I am here today to implore Congress to immediately pass the Cancer Care Reform Act, H.R. 1934, a bipartisan bill, introduced by Representatives Cathy McMorris Rodgers and Steve Israel. The bill lays out the specific plans for a demonstration project based on the Oncology Medical Home. It is built on successful models that have already been tested in the oncology payment reform with both private payors and CMS.

I commend Mrs. McMorris Rodgers for reaching out to practicing community oncologists for crafting her bill. In addition to support from oncologists, her legislation also has the support of patient

groups, private payors, biotech companies, and pharmaceutical distributors. I also commend Congress for passing a fix to SGR, along with a path to meaningful payment reform. Community oncology practices like mine want to be part of the alternative payment reform path that the Energy and Commerce Committee developed in the SGR legislation. However, we need a Medicare alternative payment model in oncology for that to happen.

H.R. 1934 is a critical bridge to getting us to that point. I ask Congress to pass this important legislation that will lower the costs of cancer care while enhancing the quality of care for patients.

Thank you for your attention.

Mr. Pitts. Thank you.

[The prepared statement of Dr. Gould follows:]

******** INSERT 1-2 ********

Mr. Pitts. Sorry to rush you here. We are going to do one more opening statement. No time left, but 290 people still haven't voted.

So, Ms. Norby, you're recognized for 5 minutes for your opening statement.

STATEMENT OF SANDRA NORBY

Ms. Norby. Chairman Pitts, Ranking Member Green, and members of the committee, thank you for holding today's hearing highlighting these important legislative issues.

My name is Sandra Norby, and I appreciate the opportunity to discuss my strong support for H.R. 556, the Prevent Interruptions in Physical Therapy Act of 2015.

I would like to especially thank Congressmen Bilirakis and Lujan for their sponsorship of this legislation.

I am a physical therapist and a member of the American Physical Therapy Association and its private practice section. My small business consists of five clinics in Iowa in communities with populations ranging from 500 to 9,000.

One of APTA's policy priorities is to improve access to care by physical therapists through the elimination of regulatory, legal, and payment policy barriers that impede patient care. Physical therapy is part of the comprehensive care model; therefore, it is high time that access to PT also receives the same protections against unavoidable absences by the therapy provider.

H.R. 556 would improve access to care by providing needed regulatory relief with a simple technical fix. This bill would allow PTs to enter into locum tenens arrangements with other qualified therapists on a temporary basis in cases such as illness, pregnancy, or jury duty. This arrangement is available to numerous Medicare providers, but physical therapists were overlooked and are not included in the law that permits locum tenens.

This means PTs in private practice are unable to be absent from the clinic, even in an emergency, without interrupting a Medicare patient's episode of care. Such interruption results in potential regression in the patient's condition. When care is resumed, the Medicare patient is likely to require more visits to achieve the original therapy goals, than what would have been realized sooner, had a locum tenens therapist been allowed. Thus, not allowing a locum tenens for PTs has the potential to increase costs to the Medicare program.

It is currently possible to hire a substitute for a planned leave by arranging for a PT to be added to the practice's Medicare certification. However, such an arrangement is not realistic for emergencies or a short-term option. The certification process is complicated and time consuming, taking 2 to 3 months under the best of circumstances, and includes an on-site visit. This cumbersome time requirement is certainly a reason that numerous other Medicare providers are permitted to use locum tenens arrangements. It only makes sense that PTs are afforded the same options.

Practicing in rural communities, as I do, my colleagues and I are often the only physical therapists in town. When we have to be gone from our clinic, our practice must turn away our Medicare patients or take extraordinary measures for them to continue their care. During a recent maternity leave for one of my therapists, I spent 12 weeks driving from my home 3 hours away, sleeping at the clinic most nights, in order for our Medicare patients to receive their care.

Under locum tenens, a clinic like mine would be allowed to bill and receive payment for the replacement therapist services. Built-in safeguards control fraud and abuse as all locum tenens arrangements must meet regulatory standards that includes identification of services on the Medicare claim form and a 60-day limit to use the provider.

Senator Charles Grassley recently received a letter stating quote: "CMS does not have evidence indicating that locum tenens, as used by physicians under current law, has led to a general increase in utilization of services; or that industry practices generally lead to the provision of unnecessary services related to the use of locum tenens; or that the use of locum tenens under current law in the Medicare program is generally inappropriate, wasteful, or fraudulent" close quote. Preventing the disruption of Medicare patients' therapy, as this bill will do, would likely result in lower costs to the Medicare program.

I truly appreciate the committee's interest in addressing this regulatory burden that impacts access to care. I am hoping that this

simple technical correction can be achieved and that Medicare patients will be allowed to continue to access medically necessary PT services without disruption.

I look forward to working with the committee, and I am happy to answer any questions you may have.

Mr. Pitts. Thank you very much.

[The prepared statement of Ms. Norby follows:]

******** INSERT 1-3 ********

Mr. Pitts. I appreciate your patience due to the votes on the floor. We are going to have to take a brief recess. We will reconvene immediately after the votes. There are still 160 people who haven't voted, so we have time.

So, without objection, the subcommittee stands in recess.

[Recess.]

RPTR DEAN

EDTR ROSEN

[10:52 a.m.]

Mr. Pitts. The time for the recess having expired, the subcommittee will come to order. I will begin the questioning and recognize myself for 5 minutes for that purpose. Can I get staff to come over here and operate this clock? One of you. I am sorry, that is okay.

We will start with you, Dr. Gould. One thing this committee focused on during the SGR debate, the sustainable growth rate -- you are familiar with that I am sure --

Dr. Gould. Yes.

Mr. Pitts. -- was creating a new framework for alternative payment models, and the goal was to encourage specialties to develop their own best practices that could ultimately lead to more coordinated care and better patient outcomes. How do you see H.R. 1934 conforming to this goal?

Dr. Gould. Well, I see H.R. 1934 fitting like a hand in a glove with that mandate. As medical specialists, we all want to be judged on the quality of our work, and we want to be judged on measures that are relevant to our specialty, and we want to be judged on how satisfied patients are with the care they receive from us.

In addition, we understand in these days that costs are important, and we also want to take responsibility for our part of the rising health

care costs. So the alternative payment model, H.R. 1934, meets all those needs in terms of payment reform, in which I applaud Medicare in terms of their moving from paying for the volume of services utilized to the quality of the services rendered to the patient.

Mr. Pitts. Thank you. Ms. Norby, what safeguards and fraud and abuse controls, if any, are built into locum tenens agreements?

Ms. Norby. As I indicated in my testimony, we have to identify who the provider was on the claim form by reporting their NPI number, and also, there is the 60-day limit that they can be utilized as a locum tenens as well.

As the letter from CMS had indicated, that these were physicians, they have not seen any problems with any kind of fraud or abuse when the locum tenens physician is in, so we assume the same would happen with physical therapists.

Mr. Pitts. Thank you. Ms. Myers, in your testimony you discuss how vulnerable a population the home health beneficiaries are. Can you elaborate on that a little bit?

Ms. Myers. Absolutely. In a number of cases that we provide services to Medicare homebound beneficiaries, some of them are wheelchair bound, many of them are in very rural areas with very little access to community and/or family support systems. There are certainly a number of patients that we serve that are severely homebound, and without assistance, truly cannot get out of the home, even to simply get to a physician's office for a visit. So there are many cases where we are dealing with highly functionally-impaired

individuals.

Mr. Pitts. So it is very important in a rural setting?

Ms. Myers. Absolutely. Most specifically, we have a lot of patients in Congressman Walden's district who have very little access to care. They may live 60 miles, 100 miles from the nearest hospital, and it is very difficult, not only for clinicians to reach them due to the rural conditions and the areas in which they live, but also, certainly, very difficult for those patients to get out to basic health care so that they may continue to be independent.

Mr. Pitts. Ms. Norby, how long does it take to hire a substitute provider for planned leave by arranging in advance for a Medicare-enrolled physician therapist to be added to the practice's CMS certification?

Ms. Norby. As I understand, you are asking how long it would take for me to hire someone to replace the therapist? In the case of my story where I covered a maternity leave for a therapist that was leaving, I did reach out to some traveling companies to see if I could hire someone to fulfill that role. They could not guarantee me that I would know who the provider was more than 30 days in advance. And with Medicare's requirement for the certification enrollment, that can take 2 to 3 months or longer. So if I had brought that person in, I would not be able to actually bill for their services for a significant duration of time, which then would put a financial hardship on our clinic because we still have payrolls to pay and those types of things as well.

Mr. Pitts. I have just one more question for you, how does Medicare save money if PTs in private practice are allowed to enter into locum tenens arrangements?

Ms. Norby. That is a great question. So right now, without locum tenens, if I had to be gone from my clinic, my Medicare patients are not receiving the care they need. And if someone had, for instance, a total knee replacement, any interruption in physical therapy to regain, for instance, their knee range of motion, is going to be very, very detrimental to the progress of their care. And so what would happen is they are going to create joint stiffness, and so then when I come back and they can get physical therapy, they are literally going to have to have more visits to achieve that goal that we set up in the first place, because they were put behind because of the absence.

Mr. Pitts. All right, my time has expired. The chair recognizes Mr. Schrader for 5 minutes for questions.

Mr. Schrader. Thank you very much, Mr. Chairman. A couple of questions for Ms. Myers, if I could. You said that the current home health documentation requirements aren't working as needed. There have been a lot of denials that seem odd or problematic, to put it nicely. Could you give us some real-world examples of some of the ridiculous things you have incurred from CMS in denial?

Ms. Myers. Absolutely, and I thank you for the question. A lot of the examples that we are seeing on claims and denials and requests for additional documentation from the reviewers include things such as a missing date, a missing signature. One denial, in particular,

was due to the fact that the reviewer could not read the handwriting of the physician, and in particular, could not read the physician's signature itself, which I find to be terribly odd because the record requires us to provide an NPI number to validate that the physician is actively billing Medicare and the system. And so it is a little bit of an oddity.

The other denials that we do see are related to the status of the clinical condition of the patient and the homebound status. Some of the denials we have seen involve the description by the physician and how he or she may describe the patient's condition. For example, one physician described the patient and their need for skilled care as a double leg amputee. To me, that is pretty clear that that patient is not going to be able to get out of bed, into a wheelchair and to do the general things that we take for granted every day. But certainly, that particular instance did require some additional documentation on the part of the physician.

Mr. Schrader. Very good. And as a veterinarian whose signature also is very illegible on a regular basis, yeah, I think most people should assume that is the case.

CMS has apparently recently released a draft form, a little different new form documenting patient eligibility. I wonder how that compares to what the current form is and if you think that is a step forward?

Ms. Myers. Well, we have certainly have been working extensively as a stakeholder in that group, and with our national association

through that process. And I think that we are seeing some movement forward, but I think that, to the extent that it goes far enough in order to avoid the thousands of denials we are seeing, we don't believe that it currently does. I think there are sections in the proposal for that new form that still require such documentation that could be subjectively denied by a reviewer and determined to be insufficient.

Mr. Schrader. Very good, very good. Thank you for your testimony, and thank you for making the trip.

Ms. Myers. Thank you.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the gentleman from Texas, Dr. Burgess, for 5 minutes for questioning.

Mr. Burgess. Thank you, Mr. Chairman. And thank you for the bills that we have got under consideration today. They are certainly worthy of discussion and certainly provide, I hope, some commonsense relief to people who are having difficulty with the agencies in trying to deliver care for their patients.

I am a cosponsor of H.R. 556, which is to prevent interruptions in physical therapy. This does seem like a commonsense approach to allow physical therapists providing outpatient physical therapy services to use specified locum tenens arrangements.

I have a constituent who wrote me, and this was a quote, "I am a contract therapist, and this bill directly affects my business and the therapists for whom I work. One private practice owner asked me 5 months in advance to cover her vacation. Although I am fully credentialed with Medicare, I have to submit paperwork to the Center

for Medicare & Medicaid Services for reassignment of benefits to the clinic. By the time of the vacation, the paperwork was still not finalized.

In lieu of denying the patient's care for the week, the business owner opted to have me proceed with providing the care her patients needed. I worked an entire week and she was not able to bill Medicare for the services I provided during that time. A significant loss of revenue for what is, after all, a small business."

So Mrs. Norby, for the record, can you explain why physical therapists weren't included in the first place? And why can't the payer, the agency, Center for Medicare & Medicaid Services, just simply pay the physical therapists through regulation?

Ms. Norby. That is a great question. The language that included the physicians, it was over 40 years old. And at that time, there was not a prevalence of physical therapists in private practice, and so that is one of the reasons that they were overlooked, because there was not a need. The landscape today is completely different.

In our State of Iowa alone, we have numerous physical therapists in small communities. In three of my clinics, we have one PT, including the clinic that I am currently practicing out of as well.

We understand CMS has been approached many times by our association and asked can we correct this, and they have said that it requires legislation to correct the technical fix for it.

Mr. Burgess. So it requires an act of Congress. Well, Mr. Chairman, I am grateful that we are stepping up to that challenge. Not

that there aren't other challenges out there, but this is one that needs to be fixed.

The face-to-face issue, man, oh, man, I have got a situation similar to what we just heard from Dr. Schrader, but we all agree it is important to combat fraud, we want to ensure patients are getting the care from the physician that was ordered. But then to deny them the care or delay it because the contractor, not anyone else in the equation, but a contractor, determined that the physician didn't do enough to meet the requirement; of course that burdens the doctor, of course it burdens the person who is the provider of the home health service, and I guess the main thing is it really does hurt the patient.

Now, again, my question is going to be very similar to Dr. Schrader's, but in the answer to his question, you said that sometimes handwriting was hard to read. I am a physician, guilty as charged, but everybody has electronic health records now, so why is handwriting even an issue any longer?

Ms. Myers. Well, I would argue that most of the documentation is done by hand. There are so many different her, electronic health record systems out there, they don't speak to each other, at least not as consistently as they could.

Mr. Burgess. So with all of these billions of dollars we paid for electronic health records, we are now disrupting every private practice across the country with ICD-10 starting today, the system still doesn't work?

Ms. Myers. And home health agencies, for the most part, do have

some form of electronic record, but in rural communities, there is no capital funding for that. So, for example, in some of the areas where we have experienced issues with, for example, Veterans Administration, and a lot of our rural providers who provide care to patients who are serviced through the VA across the border, they are finding that the VA electronic records are not even being accepted by the contractors and reviewers, and they were previously approved. So there are some problems.

Mr. Burgess. Let me just share with you, I asked a provider back home, Do you have any thoughts on this? And her quote to me is, "This policy, as implemented, has cost my business almost $1 million. I have no issue with the requirement for a physician to visit in 99 percent of the cases, and there are great and respectable physicians across the country. Not all the time do they have time to hand documents over and over and over again for Medicare contractor employees, who, themselves, have little or no medical expertise to determine whether they have adequately described, according to very loosely-fitting terms."

And I suspect this is something that people all over the country are encountering. Mr. Chairman, I hope today we are finally going to get that fixed. I will yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman. The chair now recognizes the ranking member of the subcommittee, Mr. Green, for 5 minutes for questioning.

Mr. Green. Thank you, Mr. Chairman. I want to thank our

witnesses for joining us today. I know that home health care services are critically important for Medicare beneficiaries who are confined to their homes. I have a very urban area that it is important for. However, over the last two decades, a variety of the Office of Inspector General reports have found high levels of improper payments in Medicare reimbursement for home health care.

Ms. Myers, can you describe any recent fraud reduction efforts, or any proposals underway at your agency or across the country?

Ms. Myers. With respect to fraud reduction efforts, I might want to consult one of my national colleagues about that. Certainly with the Oregon Association for Home Care, we work with all of our providers to make sure they are knowledgeable about the laws and regulations, and to make sure that they understand what the guidance is relative to implementing that, those laws. And certainly, the physicians are subject to many antifraud laws, and so it is important -- a critical piece of the process.

Mr. Green. Okay. Dr. Gould, thank you for your testimony. I think your testimony helped confirm something we in the committee have long thought, traditional fee-for-service has not done a great job of incentivizing care coordination. That is why we started moving towards alternative payment models in the Affordable Care Act, and then we built upon the reforms of the ACA in the recently-passed Medicare Access and CHIP Reauthorization Act of 2015 for its repeal of the flawed sustainable growth rate formula, and replaced it with incentives that switched alternative payment models that put value and quality care

over volume.

Alternative payment models in cancer care have a lot of potential, both to improving care, coordination, and quality and reduced cost. It sounds like you are doing some of the work in cancer care, both through public and private partnerships to test payment reforms. Specifically, you testified you have successfully been able to reduce costs through alternative payment models. Can you talk a little bit about how you were able to achieve these lower costs?

Dr. Gould. Yes, sir. I fully agree with your remarks. Basically, it comes down to the physicians within a practice making the commitment that they want to transform their practice from the old way of doing things to the new way of doing things, which is not only taking care of the patient medically, but being more thoughtful in terms of the resources utilized to take care of that patient in making sure that whatever we do for that patient is going to have a meaningful impact on their health. And our national societies have put out the Choosing Wisely program, which outlines things that physicians calmly do that do not add value to the care of the patients, and there are certainly many more examples than what is put out by our national societies. So in our practice, for instance, as I mentioned, one of the things that we did was to implement treatment guidelines to make sure that all patients got state-of-the-art care that was appropriate.

Secondly, we talk at length about end-of-life care to make sure that the patient gets the appropriate end-of-life care, sometimes doing less is better than doing more.

Thirdly, we have made a big investment in the infrastructure of our practice by hiring at least -- almost a 1-to-1 ratio of physician extenders to physicians so that we have plenty of room in the office schedule to take in patients who need to be seen urgently as opposed to sending them to the emergency room.

A lot of times when patients get to the emergency room, they are seen by an ER doctor who doesn't have the level of comfort that we do in terms of treating these patients as an outpatient, and then these patients automatically get admitted.

And then, finally, in the development of our treatment guidelines, we always put the interests of the patient first in terms of what is the most effective treatment and the least toxic, and we do not take economics into the equation. So, all of those practice processes have made us a leader in the oncology medical home. And then, I have been a leader, personally, in terms of helping educate and in disseminating this model across the country.

Mr. Green. Well, obviously, I appreciate it and I know it is difficult for physicians to go between paper and electronic medical records, but also, with a lot of the things that are changing in the practice of medicine, and it affects Members of Congress, too. My staff finally told me I can't get a new -- my old BlackBerry back because they don't have screens anymore, so I have to go to a new model. You know, change is tough for folks, how they do it. But again, electronic medical records and the coordination, and they need to talk to each other from practices. And it sounds like what you all have done has

been able to do that, because I have a very urban district, but I have a group of physicians in the area that all go to one hospital, and they were able to do that and with their practices, and so, they could share, because they share their patients all the time with each other.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. Mr. Bucshon, you don't want to question?

The chair recognizes the vice chair, Mr. Guthrie, for 5 minutes of questions.

Mr. Guthrie. Thank you, Mr. Chairman. Thank you for yielding.

Dr. Gould, my first question is, we are talking about the payment model established in the bill. How large is your practice? And I guess my question is, do you think this payment model would work for different-size practices and would hospitals be able to participate in the demonstration project created by the bill?

Dr. Gould. Yes, sir. So, my practice has 21 physicians, and we have a pretty sophisticated management team. But at the end of the day, as I mentioned in my earlier remarks, it really takes the commitment of the physicians to want to change and do a better job in controlling costs.

We all recognize that healthcare costs are spiraling out of control, and for us to get a handle on things is going to require that each stakeholder that has a hand in rising healthcare costs take responsibility. And the oncology medical home is the attempt by the community oncologists to control those things that they can, such as

hospital utilization, making sure drug therapy is being used appropriately, doing a better job at the end of life where a lot of times treatments are not impactful in terms of the patient's quality and quantity of life.

So obviously, it is going to be a little easier for larger practices to make the transformation, but there are a lot of well-run, smaller practices that should be able to make the transition as well.

Mr. Guthrie. I believe you understand, or know, that CMS is in the process of developing an oncology care payment model. How does the model established in this bill, H.R. 1934, different to what CMS is trying to accomplish, and why is the bill better?

Dr. Gould. So it is not like one is better than the other. First of all, both programs have, as their heart and soul, the oncology medical home. I, personally, along with a lot of my community oncology colleagues, gave input to the Brookings Institute which helped craft the oncology care model. But the big difference between the two programs, and I can say we applied for the oncology care model, by the way, is the number of physicians that the programs touch. In the oncology care model, it is only open to 100 practices, whereas the H.R. 1934, that opens this new payment, alternative payment model, to up to 1,500 physicians. So, the impact of H.R. 1934 potentially is going to be much larger than the OCM.

Mr. Guthrie. We always appreciate when groups come forward, and this is an opportunity for us to help you save money within our field, because if it is bottom up, or driven up and brought to us and people

are invested in it, and so they really make it work. So, I guess the question is, we all focus on saving money in the spiraling health care costs. But how does this benefit -- how would the medical home benefit patients specifically?

Dr. Gould. Sure. Great, great point. Obviously, in my work as the chairman of the co-oncology medical steering committee, the first group that we interviewed to get their perspective on what is quality and value in terms of cancer care was the patients and the patients' advocacy groups. We interviewed a slew of patients and patient advocacy groups, and basically, kind of consolidated their needs, so to speak. And then, along with other providers we helped develop processes to make sure that those patient stakeholder needs are met. And as part of H.R. 1934, the oncology practices are not only required to report on quality measures that are driven by medical good care, but as part of that program, there is a patient satisfaction survey.

Mr. Guthrie. I just have about a minute, and I want to ask one more question. I appreciate your -- I think we got what we needed.

Dr. Gould. So anyway, there is a patient satisfaction survey built into --

Mr. Guthrie. So Ms. Norby, in the piece of legislation that you are here to testify, if it is passed, how would this legislation affect your business and businesses of other small PT clinic owners.

Ms. Norby. It is critical for the continued longevity of our businesses, and really, critical for the Medicare patients in those communities. As I said, three of our five clinics have only one

physical therapist in that clinic. When I go back to the maternity leave that I personally covered for, if we -- our only options were to either hire a substitute to come in, or to close the clinic for that length of time. Closing the clinic was not an option. We had a commitment to the community to bring our practice there and to treat the patients and provide them access to care that was local and convenient for them. So that was our first and foremost.

To hire a substitute, as I indicated, we would have to enroll them in Medicare provider, and that can take up to 3 months, which then we can't bill Medicare. Now, granted, we have had to do that when we hire new therapists, and we always bank locally in the communities that we do, and they have been very gracious to offer me a short-term line of credit to cover salaries and pay rent while we are waiting for Medicare enrollment, but that -- this is a clinic in a town of 500, small margins, that was not an option either.

Mr. Guthrie. Thanks, my time has expired. I appreciate the answer. My time has expired. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from New Mexico, Mr. Lujan, for 5 minutes for questions.

Mr. Lujan. Thank you, Mr. Chairman. Mr. Chairman, in June, the Congressional Budget Office provided a score to the Senate companion of the Prevent Interruptions to Physical Therapy Act as amended by the Senate Finance Committee. In determining the cost for the bill, CBO raised questions about increased utilization and suggested that locum tenens would result in a cottage industry. Fortunately, Senators

Grassley and Casey, who are the lead sponsors of the Senate bill, wrote a letter to the Centers for Medicare & Medicaid Services asking if there was data to support CBO's assumptions.

CBO responded, "CMS does not have evidence indicating that locum tenens, as used by physicians under current law, has led to a general increase in utilization of services, or that the industry practices generally lead to provision of unnecessary services relating to the use of locum tenens, or that the use of locum tenens under current law in the Medicare program is generally inappropriate, wasteful or fraudulent." I would like to ask unanimous consent to enter into the record the letter from Senators Grassley and Casey to the Secretary of Health and Human Services and the response from HHS to both Senators Grassley and Casey.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Mr. Lujan. Thank you very much, Mr. Chairman.

Ms. Norby, you know, I had the honor, I guess you could call it, of getting to see firsthand the work of physical therapists and the benefit of therapy. In the early 1990s, I was sadly the victim in a head-on car accident with a drunk driver, and it was physical therapists who once the docs on the other side gave me the release that really put me back together, if you will, from being able to move, and being able to just walk around. So I just want to say thank you to you and to everyone we had the honor of working with.

As you know, the locum tenens agreement is a longstanding and widespread practice for physicians to retain substitute positions in the professional practices when they are absent due to illness, pregnancy, maternity or paternity leave, jury duty, vacation or working to continue their medical education. This makes it acceptable for the regular physician to bill and receive payment for the substitute physician services as if they performed themselves. Physical therapist practices are similar to physician practices and like physicians, there are times when a physical therapist practice owner must be away for a short period of time. Under current law, physicians, osteopaths, dental surgeons, podiatrists, optometrists, and chiropractors can navigate these circumstances easily by entering into a locum tenens agreement with a qualified substitute provider.

What options do physical therapy private practitioners currently have when they need a physical therapist to fill in? And I think you went over this quite substantially. You have already addressed the

timeframe that it takes. Do you feel there is an opportunity for fraud and abuse if physical therapists in private practice are included as providers at locum tenens?

Ms. Norby. No, I don't feel that there is a potential for fraud and abuse. The locum tenens physical therapist would be seeing the patient that I would have been seeing if I was in the clinic. And we would be reporting their services on the claim form by utilizing their NPI number reporting who provided that care. I feel very strongly that they don't have the access to their Medicare provider enrollment number to take after they leave, they are just being paid for services that they are providing at that time.

Mr. Lujan. I appreciate that. You addressed the other questions that I had which are, what are the potential setbacks to patients and clients? I can attest that if there was an interruption of me being able to go to the therapist at that time, I can't imagine what would have occurred. So when we are talking about our parents, our grandparents, loved ones, constituents, it is important that they have the continuity of care. So thank you for being here today.

Dr. Gould, I want to thank you for sharing a little bit of the unfortunate loss of your parents to cancer. I sadly lost my father to cancer a few years ago, but what you are testifying to today is very important, the legislation that both Congressman McMorris Rodgers and Congressman Israel have put forth is something that I am definitely very interested in. And I appreciate what you said when asked the question about the two programs: One is not necessarily better than

the other, they both have different trajectories, different projects, different approaches, to making sure that we can provide the best care.

Is there, in your mind, a professional opinion, sir, that maybe both programs could operate parallel to one another because of the focuses that they would both bring?

Dr. Gould. Yes. I mean, I think they are designed to do exactly that. A lot of practices did not apply for the OCM because they just felt that the application was a bit onerous and opted not to apply, and if every practice in the country applied to OCM, it is only limited to 100 practices. So there has got to be another pathway, so to speak, that runs parallel to the OCM, and that is what H.R. 1934 is designed to fulfill.

Mr. Lujan. I appreciate that, sir. And Mr. Chairman, I know my time has expired, but Ms. Myers, for traveling all the way from Oregon, thank you so much for taking the time. New Mexico, like Oregon, is a very rural State. It takes 8-1/2 hours to drive across my congressional district. And so it is not just a matter of the testimony that you are bringing today of the information being on paper, it is the sheer geography with physicians driving 2 and 3 hours to get into some of these communities. So thank you very much for what you are doing. I appreciate the work of Mr. Walden in this area, and I look forward to working with him and yourself, Mr. Chairman, and our members on this issue. Thank you very much for the time, sir

Mr. Pitts. The chair thanks the gentleman and agrees with his last statement. Thank you very much for coming.

The chair now recognizes Mr. Bilirakis from Florida 5 minutes for questioning.

Mr. Bilirakis. Thank you very much, Mr. Chairman.

Ms. Norby, in your testimony, you very briefly talked about the challenge your practice faced when one of the therapists was away. So, again, it is the geography, but also, the small practice that has difficulties. Can you elaborate more on what happened with your business? What problems this created? And how badly this inconvenienced both patients and physical therapists, please? Thank you.

Ms. Norby. Yes, I sure will. Thank you for the question. So, like I had indicated, we have made our mission to provide physical therapy care in communities that don't have access to care. And so when a therapist has to be gone for any type of reason, the Medicare patients within that community have been afforded to have local convenient care, and they are happy about that, and they -- physical therapists, we develop our relationship with our patients. They don't necessarily want to see anybody else.

In the particular instance that I had, the next closest physical therapy clinic was 45 miles away, and it was winter. And so the Medicare patients, they were not going to drive to those clinics to be able to receive their care. So it was imperative and our commitment was to provide that. So that is why I went in and covered that maternity leave.

When we set up a clinic, I have the flexibility at that time to be a substitute provider and so I was medically -- I was an enrolled Medicare provider for that clinic. That situation has changed now, and I am currently practicing full-time in one of our clinics as the solo PT.

So in the future, if this happens again, which it will, they will have more children, we do not have the opportunity for me to actually be the one to physically go there. So this is extremely important for the communities that we serve, and for our small business as well. As I had indicated, because we have to wait, we have to hold claims before we get the Medicare provider enrollment, that puts a significant

hardship on our small business financially. And we have had local bankers that have been very generous to literally offer us a short-term line of credit to be able to continue to pay salaries, and pay rent and that type of thing. That is not an ideal situation, so locum tenens is crucial.

Mr. Bilirakis. Thank you so much. Ms. Norby, will giving physical therapists the ability to use locum tenens arrangements increase waste, fraud and abuse in the system or cause access utilization of services? Is there any evidence that locum tenens arrangements leads to these problems? I know that Ben and others have touched on this, but I want to give you the opportunity, and I have something to submit for the record as well.

Ms. Norby. Okay, awesome. No, the therapist would see my patients in my absence and so they would -- that would be indicated on the Medicare claim form by their NPI number, so the visits that would have been scheduled for the patients to see me are now just rescheduled to see the substitute therapist.

Mr. Bilirakis. Thank you. Mr. Chairman, I ask unanimous consent to submit this letter from CMS which states that CMS doesn't have evidence locum tenens leading to increased utilization, or that locum tenens leads to fraud.

Mr. Pitts. Without objection so ordered.

[The information follows:]

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Mr. Bilirakis. Thank you. If a physical therapist -- again, ma'am, if a physical therapist is out for an extended period of time, their patients may have to cancel or reschedule or may forget to reschedule future appointments. Can you talk about how important it is for seniors to maintain their physical therapy regimen?

Ms. Norby. It is very important. Physical therapists, we are movement specialists, and we help people be able to stay functional in their homes, and to stay longer in their homes as well. And so when a patient, a Medicare patient accesses physical therapy, they have a problem with their movement. And when we determine our plan of care and start to treat that patient, we are progressing them through to be able to get their goals to move better, or to regain function.

Post-surgical care is very, very critical to be able to have consistent physical therapy. Otherwise, stiffness of the joint can occur that then becomes very painful to try to regain that motion, and it does take longer for them to do that. I know two patients, in particular, that they had to interrupt their care because one had a gall bladder attack in surgery, the other their spouse died unexpectedly. And they came back after those incidences with very stiff joints, and it literally doubled the amount of visits that they needed to have to get to their original goal, because they were without care for a period of time. And so if I had to be absent and I couldn't have a substitute come in, that would be bad as well.

Mr. Bilirakis. Thank you. I guess I have 3 seconds. Can I ask one more question, Mr. Chairman -- actually, I am over.

Mr. Pitts. You may proceed. Go ahead.

Mr. Bilirakis. One more? Thank you.

Can you describe how locum tenens works, and why a physical therapist can't just pick up a substitute for a physical therapist during staffing shortages? Does private insurance also allow for locum tenens? I just want you to have an opportunity to elaborate.

Ms. Norby. No. A great question. Private payers do offer locum tenens, all of our commercial payers in Iowa do, and across the country. But in order, in a private practice setting, to be able to see a Medicare patient, as a physical therapist, I have to be provider-enrolled under that tax I.D. number and that location. So I cannot just have another substitute come in and see my patients legally, because I cannot locum tenens without them going through that process.

Mr. Bilirakis. I thank you very much. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questioning.

Ms. Schakowsky. Thank you, Mr. Chairman. I want to apologize to the panel for missing your testimony, but I did have an important question to ask. But first, I just wanted to say, Ms. Norby, I am a happy user of physical therapy. I have very weird feet that I would like to keep working for another couple of decades, who knows, and so I am, right now, taking physical therapy and can see its results. So I just wanted to tell you that.

So I wanted to talk about the staggering cost of prescription drug prices in this country and the burden this places on patients and families. Sadly, I am well aware of that. My precious daughter-in-law passed away from cancer, but it put a tremendous strain on the family financially, in terms of having a 5-year-old and a 3-year-old also left to my son.

So it is an issue that I think we really have to be discussing more, and I know a majority of Americans agree. In fact, 73 percent of the public think that the cost of prescription drugs is unreasonable. Cancer treatments, in particular, are increasingly bankrupting patients. The average cost of new cancer drugs and other specialty drugs continue to increase each year at an unsustainable rate. We saw this dramatic example of the $13.50 pill that the hope of the owner of the company was to raise it to $750 a pill. But even less dramatic, a recent study from the American Economic Association's Journal of Economic Perspectives showed that cancer drug prices increased 10 percent every year from 1995 to 2013. And Mr. Chairman, I would like unanimous consent to place that study in the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Ms. Schakowsky. So while the average American family makes about $52,000 a year, there are cancer drugs on the market that cost more than $100,000 per year. Even those fortunate enough to have insurance can face out-of-pocket expenses that add up to more than half of the family's income.

I think we can all agree that drugs only work if patients can actually afford to take them. And I worry that if we don't act soon, these skyrocketing prices will leave the majority of Americans literally priced out of a cure.

So, Dr. Gould, I am sure you have seen firsthand how difficult it can be for a patient to pay for their treatment. I am wondering if you have any experiences as to how the rising drug costs have affected the patients that you are treating?

Dr. Gould. What you are describing is a new concept in medical oncology that we hadn't talked about until a few years ago, and that is called the financial toxicities of our therapies, and not just the medical toxicities. Clearly, that is a concern to us at the Community Oncology Alliance, and we meet regularly with the pharmaceutical companies, and we make the points that you just made loud and clear.

Unfortunately, at this point, we have got limited ability to influence how the manufacturers price.

Ms. Schakowsky. Let me ask you this: I am wondering if you can discuss how the alternative payment methods, such as the Center for Medicare Medicaid Innovation, Oncology Care model, might address this issue?

Dr. Gould. Yes, that is exactly where I was going.

Ms. Schakowsky. Thank you.

Dr. Gould. So as I was saying, to contrast, we don't have a lot of control over how the manufacturers price their drugs, but what we do have control over is, one, how we utilize those drugs and making sure that those drugs are being utilized with the right patients at the right time for the right disease.

Secondly, we do control a large part of the healthcare dollars such as hospital utilization, emergency room utilization, and radiation therapies and radiology therapies. As community oncologists, we are imploring our colleagues to take more ownership of the health dollars that we do control, and the alternative payment models, such as the oncology care model and H.R. 1934, really not only give extra incentives to the practices to do a better job in controlling those dollars, because if they do a good job controlling the dollars, then there is a financial reward associated with that better utilization of the healthcare dollar, only if the quality of care is maintained.

Ms. Schakowsky. Thank you so much. I just wanted to point out the oncology care model was part of, and CMMI, part of the Affordable Care Act that I think can help us all deliver better care, and do it at a better price. So thank you and I yield back.

Mr. Pitts. The chair thanks the gentlelady. I now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. Collins. Thank you, Mr. Chairman. I am very happy that we

are having this hearing today on ways to improve our Medicare program. In a couple of the bills that are up for discussion are very important, including H.R. 556, the Prevent Interruptions in Physical Therapy Act, which was introduced by my good friend, Mr. Bilirakis, and I am a proud cosponsor of that bill. That bill came to my attention because of the significant number of physical therapists in my district, western New York, very rural, who reached out to my office, and pretty much articulated the same problem we have heard discussed already, finding someone else to take care of their patients if the PT needs to go out of town for any variety of reasons.

Mark Howard, the owner and chief therapist of a very small private PT practice in Depew, New York, western New York again, recently wrote to me, and he said when he goes out of town, either to attend a seminar or perhaps getting the continuing education units that he would need to stay compliant with our State regulations, his wife, who is also a PT, takes over for him. So in that case, he doesn't have a problem. But he said there are times he and his wife travel together, and at that point, there is a problem. That is when they have to find a replacement therapist, assign their payments, which can take several weeks, and a lot of advanced planning, as you very well already discussed. If they didn't do this, the elderly patient care would be interrupted, obviously, as you again explain, setting back their treatment schedules.

So I really think, Ms. Norby, you handle that very well, and Mr. Bilirakis covered that in a lot of detail which we, I suppose, could

go back over, but I think that has been discussed. So I would like to maybe switch, and even though today, while we are primarily talking about patient payment plans, Dr. Gould, I would like to also talk about patient access, because they are kind of related. But in particular, in reading through your testimony, I noticed you reference that there is a large number of community oncology practices that have closed or have been forced or have chosen to merge with various hospitals. And certainly my concern in this regard is on the access piece.

I just wondered if you could discuss any of the reasons, perhaps unintended or otherwise, but some of the reasons that have caused so many, especially oncology practices, to merge under hospitals?

Dr. Gould. Yes, sir. I would say that there are two forces in play here, we have what I like to call a push, then we have the pull. The push forces I would characterize as four major forces. We have increase in cost of doing business. Our costs go up just like everybody else, including for health care.

Secondly, we have had declining reimbursement, particularly from Medicare. And I mentioned one example, which was the sequestration cut.

Thirdly, we have the increased cost of doing business, particularly with the increasing regulatory environment. And then fourthly, we have the uncertainty of future government programs and how that is going to impact Medicare reimbursement and so forth.

So on the other hand is the other force that I call the pull, which is that many hospitals have access to the 340B program, and for those

hospitals to be able to access that program, they have to have contracted physicians, either directly employed or contracted through what we call a physician service agreement, or a PSA. And so, you know, with the increasing challenges in trying to run a practice, a lot of physicians are saying heck with it, I don't want to be bothered with all of this, I just want to be able to take care of my patients. And so the hospitals are singing a siren song, and these physicians are going to work for the hospitals and not worrying about the management of a practice.

Mr. Collins. So let me interrupt there, because I heard this before. Is it safe to say a private oncology practice would not have 340B pricing?

Dr. Gould. That is correct, sir.

Mr. Collins. So in this case, if I have this right, a 340B hospital, and we are talking about very expensive oncology drugs, I mean, these could be $100,000-type drugs. So in the 340B setting, there is a private oncology practice, they treat a patient, there is a $100,000 pharmaceutical, they are covered by Blue Cross/Blue Shield, it is prescribed, Blue Cross/Blue Shield pays it and we move on. But now, if the same practice merges under a hospital, the same drug is given, the same reimbursement is made by Blue Cross/Blue Shield, to give an example, but then that hospital turns around and gets a discount from the drug company and get that drug for $20,000.

Dr. Gould. That is correct, I mean --

Mr. Collins. In which case that $80,000 goes to the bottom line

of the hospital, which actually, in a profit-motivating world, would allow them to pay a lot of money for private oncology practice. The primary financial driver of that is nothing more than telling the pharmaceutical companies they are going to take it on the chin, have to pass this discount on because it a 340B situation, but nothing else has changed. I know my time has expired, but is my understanding of that fairly accurate?

Dr. Gould. Yes, sir. And what happens is, those hospital practices now have more monies to compete for employees and doctors than what I have in private practice, and so, I go out of business and have to partner with hospitals as well.

Mr. Collins. I know my time has expired, but that goes back to picking winners and losers, and we are not supposed to be doing that. With that, Mr. Chairman, I yield back.

Mr. Pitts. The chair thanks the gentleman. I now recognize Mrs. Brooks from Indiana for 5 minutes of questions.

Mrs. Brooks. Thank you, Mr. Chairman. I want to commend the chairman on continuing to tackle this complex and important issue by bringing up these bipartisan bills today and ensure that we keep moving forward to ensure that seniors get the access to the care that they need. And I think the bills before us today will strengthen existing programs and build upon the momentum that we started in the field with SGR reform.

I am particularly happy and want to focus on Mr. Walden's bill before us today addressing the issue with CMS's current face-to-face

rule. I have long said that these rules initially put forward by CMS are imposing crushing burdens on home health agencies rules and impair their ability to provide seniors the home health services that they deserve.

Complicated, confusing, inconsistently enforced, the current face-to-face regulations have exceeded the intent of the law, and I believe has hindered the work of caregivers at home health agencies. And it is having three real-world implications for three home healthcare agencies operating within my district.

The survey actually found that 52 percent of face-to-face claim denials resulted mainly from Medicare's determination that physician's documentation was insufficient, even though medically necessary care was provided. I believe this is creating an access-to-care crisis, particularly in rural parts, not only in my district, but across the country. And it is preventing providers from delivering vital services to those most in need. Speaking of, home health patients are more likely to be women, more likely to be older, more likely to be sicker, poorer, and minorities. And I think Mr. Walden's bill makes commonsense reforms to bring the CMS rule into the scope of the intent of the law.

So I would like to just ask you, Ms. Myers, a few questions. Can you give us any real-world examples of issues about the current documentation requirements that aren't working as intended?

Ms. Myers. Absolutely. Thank you for that question. We have spoken a little bit about some of the examples of claim denials. In

one additional example that I have, an orthopedic surgeon was treating an 82-year-old patient and referred them to home health care following a total knee arthroplasty, which had to do with the knee itself. Certainly this woman was wheelchair bound.

It took five attempts from the home health agency in working with the physician's office to get confirmation and documentation back from the physician. So that is one example where the physicians are extremely fed up with the documentation requirements and the difficulty.

We have talked also about the fact that there are other issues related to things like signatures, dates, missing documentation, or descriptions of documentation that have fallen under that insufficient and subjective mode from the reviewers.

Mrs. Brooks. Can you tell me whether or not the impact of these denials, or the problems with the documentation, how is it affecting the small and the rural agencies?

Ms. Myers. Well, certainly, we have a number of small and rural agencies on the east side of Oregon, which comprises, you know, most of Congressman Walden's district. In those cases, there are certainly less staff, less ability to be competitive, to hire good clinical nurses and physical therapists to provide the care for the patients that is needed at home. So it has both an impact on the agency in terms of attempting to spend less time on paperwork, and chasing documentation, and more time in patient care.

Mrs. Brooks. Do you have to, what I suspect, the agencies have

to often hire extra administrative staff to take care of all of the documentation? Is that what you are seeing? Or is it actually the providers that are trying to do what is administrative work?

Ms. Myers. It is a little of both. In the case of smaller and rural agencies, they have less of an ability to hire additional staff. I have one particular example of a provider in Wheeler County, and the agency is the only provider in that county, and faced closure this year. She is a nurse, she provides care in the community, she is traveling 60 miles to treat farmers, ranchers all over the county. And her inability to manage both patient care and handle denials and paperwork related to all of this documentation are really making that agency struggle significantly.

Mrs. Brooks. Do you have any idea roughly how many patients she cares for?

Ms. Myers. I think it is between 5 and 10 in the entire county.

Mrs. Brooks. Can you talk to me a little bit more about the issues between how is the face-to-face requirement straining the relationship between the physicians and the home health providers? What is happening with that?

Ms. Myers. It has created a relationship of almost antagonism, and it is as if the home health agency is the antagonizer, but certainly, we are just the bearer of the regulation and the rule and the requirement. So it is straining that relationship in ways that it normally wouldn't be.

Mrs. Brooks. Thank you. My time is up.

Mr. Pitts. The chair thanks the gentlelady, and now recognizes the gentleman from Oregon, Mr. Walden, for 5 minutes of questioning.

Mr. Walden. I thank the chair for this hearing, and our witnesses for their testimony. I am going to follow up on what Ms. Myers said, Ms. Brooks, because when she talks about four or five patients being served in Wheeler County, there are only about 1,700 people in the entire county. And if you drove from Fossil, Oregon, the county seat to the nearest hospital, it would be 142 miles each way. These are enormous areas, and my colleague from New Mexico, Mr. Lujan, talked about the size of his district and everybody kind of gasped. His is 47,271 square miles. Mine is 69,341.

So when we are talking about providing basic services in these remote areas, this is life and death, literally life and death. That is why this matters so much that when some contractors, some bureaucrats, some rule writer comes up with one of these things back here in Washington, they don't have a clue what they are doing in real life out on the ground, and that needs to change, and it needs to change now.

Let me go to Ms. Myers. The original requirements for a physician face-to-face encounter were intended as a program integrity measure to protect waste, fraud and abuse. Do you think this bill that we have before us eliminates or dilutes that protection against fraud and abuse?

Ms. Myers. Absolutely not. The requirement for the face-to-face encounter with the patient is still fully maintained with

the proposed bill. And it further is required, and a condition for payment under the Medicare home health benefit. The physicians still must certify the patient's eligibility for coverage, and the bill provides for a cleaner, more standardized process by which we would be able to operate and be able to focus more on patient care rather than chasing paperwork.

RPTR SCOTT

EDTR HUMKE

[11:52 a.m.]

Mr. Walden. I had a very positive discussion with Mr. Lujan during the break, when we went to vote on the House floor and come back, and he and I intend to work closely on this legislation.

Mr. Griffith and I had a very good conversation. I imagine he won't talk about this, I won't steal his thunder, but I will give him full credit that is, perhaps, within the context of this legislation, we should allow face-to-face to qualify over electronic devices.

Again, if I could take my phone into the home and have the doctor on the other side, which we all know can be done today, why should we have to transport a patient 142 miles over icy, foggy roads for a face-to-face so they can go back home?

Ms. Myers. Absolutely, and in the case of my father, right before he passed away, I was attempting to get home care for him, but he couldn't stand up, literally, make it to the car and have my mother help him to get into the car to make it into a physician's office. So it is very challenging, and that may present an opportunity.

Mr. Walden. We went through the same sort of event with my mother-in-law, who had severe rheumatoid arthritis, who was in very bad shape, and they would have to transport her by ambulance or the equivalent, and they'd have to do the blood pressure test before she left, which drove excruciating pain throughout her body, and then as

soon as she got to the hospital or whatever, they had to do it again.

I mean, there are so many stupid things in delivery of care right now, driven by either litigation or regulation that we need to get past so we put the patients first.

I ask unanimous consent, Mr. Chairman, to enter into the record a statement written by Jeffrey Weil, who is Division Vice President for Operations in the northwest for LHC Group. Jeff is responsible for the operations of Three Rivers Home Care in Grants Pass, in Medford, Oregon.

He says that, just for 2014 and 2015, his company has had more than 393 claims denied for inadequate face-to-face documentation. Each and every one of these claims had documentation signed by a physician. However, in most cases, the Medicare administrative contractors denied the claims because they deemed the physician's narrative to be inadequate. Many of these denials were reversed, but they currently have more than $1.5 million of denied face-to-face encountered claims tied up in appeals at various stages.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Walden. Oh, thank you, Mr. Chairman.

Ms. Myers, can you describe in more detail the impact that claim denials and the subsequent appeals associated with the home health face-to-face requirement has on patient care and home health agency operations, particularly in these small and rural areas?

Ms. Myers. Absolutely, and as Jeffrey Weil indicated, you know, many of the agencies across the State are experiencing very similar situations with thousands of dollars pending.

Certainly, the impact to patients occurs where the physicians these days are getting, you know, arguably, very fed up with the documentation requirements and that they simply have said to some of our providers, forget it. The documentation is too much. It takes too much time and too much time away from patient care. And unfortunately, in some cases where the physician is struggling over -- with this documentation to make a referral for home health care, they are just simply saying "no." So the patient gets caught in the middle.

And, as I have said previously, the denials are, you know, plentiful on a lot of technicalities and semantic issues, and, certainly, that needs to be fixed, and we think that this bill would help tremendously to do that.

Mr. Walden. Thank you, Mr. Chairman.

Mr. Pitts. The Chair thanks the gentleman.

I now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. Ellmers. Thank you, Mr. Chairman. I didn't realize I was next, but I am very happy.

Thank you to our panel for being here and for this particular subcommittee hearing. It is so important. I would like to associate myself with the gentleman from Oregon and his comments about the importance of us moving forward with good legislation so that we can take care of these patients in the way they need to be taken care of and stop having to jump through the hoops and put these patients and their families through this.

I do want to ask a couple of questions. As far as, you know, the beneficiaries of Medicare -- I mean, I know you have probably answered this a million times; but isn't the effect -- and it is really a "yes" or "no" answer for all three of you. The impact will be tremendous if we can change the legislation and move forward with much more -- giving our physicians, our physical therapists much more control over this situation and payment and reimbursement. I mean, this will move mountains, do you agree?

Okay. You are all indicating "yes." So I agree with that as well. It is definitely something we have needed.

And, you know, physical therapists in our rural communities, especially, are just vital, absolutely vital. Whether we are talking about physicians or whether we are talking about physical therapists, a home health setting, it is incredibly important to be able to allow the individuals to stay in their homes. We know that that has an impact on their health care.

As far as locum tenens, how would this affect reimbursement or payment for locum tenens when -- you know, I know you were discussing how, you know, you would have had to have closed if you didn't have someone that could take that space and keep your operation going. What would you like to say about that, Ms. Norby?

Ms. Norby. That is a great question. So, it affects payment because I would be able to bring in, under locum tenens, a licensed, qualified physical therapist to continue the care with my patients, and then we would submit the claims under my Medicare provider enrollment number to Medicare, so --

Mrs. Ellmers. And it would all, basically, go under your Medicare number --

Ms. Norby. Right.

Mrs. Ellmers. -- but that person would be fully qualified, able to do it, all checked out ahead of time --

Ms. Norby. Yes.

Mrs. Ellmers. -- and would just fit into that space.

So that is a very convenient and sensible way of dealing with that issue and is definitely something that I think is so important. Because, seriously, what are you doing? I mean, you really have no alternative right now the way the system is set up.

Ms. Norby. That is correct. I am gone from my clinic 2 days this week to be here --

Mrs. Ellmers. Yeah.

Ms. Norby. -- with you, and it took creative scheduling. Now,

my Medicare patients -- I am very much an advocate for this, and they all know about this bill.

Mrs. Ellmers. Good.

Ms. Norby. So they were very supportive and willing to come at 7:00 at night or at 10:00 on Saturday morning.

Mrs. Ellmers. To accommodate so you could be here.

Ms. Norby. Yes, so I could be here, so --

Mrs. Ellmers. Oh, that is awesome.

See, this is what our health care providers do. I mean, the commitment that our health care providers have for their patients, for their families, and the role -- that is why, I mean, I am so passionate about health care, you know, being a nurse and being in that space and knowing what goes on behind the scenes that people are completely unaware of; and so, you know, I am there with you.

I do want to ask a little bit about -- you know, we were talking about, really, the cumbersome nature of the paperwork, the documentation that our health care professionals -- right now, especially, is the most difficult time; and I am probably making more of a comment than I am asking a question, but I think you are going to agree with me, so I am going to assume that, and I will ask if you agree.

Right now, our health care professionals are dealing with electronic health records, meeting meaningful use. They are moving forward with stage three, which I think is a big mistake. We have a very important letter with, gosh, well over 120

cosponsors -- bipartisan -- asking them to step back from moving forward; and now we have ICD-10 that is added into the mix on top of the difficulties that are being experienced in -- especially in the home health setting. One "i" that isn't dotted, one "t" that isn't crossed can mean the difference between reimbursement for a health care professional or not.

Do you agree that right now is just an incredibly difficult time for any health care provider when it comes to the documentation? And, mind you, we are all supposed to be going paperless. I will just throw that in there. Do you agree?

Ms. Norby. And regulatory burden, too.

Mrs. Ellmers. Yes, and the regulatory burdens that are affected.

And that is what this legislation is about. We are trying to make things better. We are really trying to work behind the scenes, and I am just excited to be a part of it because I have been out in the real world. I know what it is like, and, you know, I know the commitment that our health care providers have. I know the dedication that the families of those patients have and the meanings. They will never forget the things that you have done for them ever, and any way we can make that better is exactly what we need to do.

So, again, I thank you for your time. Thank you for really, you know, taking away from your back home patients and care and families of your own to be here for this important, important subcommittee hearing. Thank you so much.

And thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentlelady. That concludes the questions from the members present. We will have written questions and follow-up from other members who weren't able to attend sent to you. We ask that you please respond promptly.

Ms. Myers. Absolutely.

Mr. Pitts. Thank you. And I will remind members that they have 10 business days to submit the questions for the record, so they should submit those questions by the close of business on Thursday, October 15.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. A very informative, excellent hearing. Thank you for coming all the way to this hearing. We really appreciate it. Thank you for your expert testimony. These are very important, bipartisan, noncontroversial bills. We expect them to move very soon, and you have had a great part in that. So thank you very much.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 12:00 p.m., the subcommittee was adjourned.]