U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

July 20, 2017

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing entitled "Examining Bipartisan Legislation to improve the Medicare Program"

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Thursday, July 20, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building. The hearing is entitled "Examining Bipartisan Legislation to improve the Medicare Program."

II. WITNESSES

The Subcommittee will hear from the following witnesses:

- Brett Kissela, Professor of Neurology, Chair, Department of Neurology and Rehabilitation Medicine, University of Cincinnati Gardner Neuroscience Institute, on behalf of American Academy of Neurology;
- Lisa Bardach, Speech-Language Pathologist, ALS of Michigan;
- Varner Richards, Board Chair, National Home Infusion Association;
- Mary Grealy, President, Healthcare Leadership Council;
- Justin Moore, CEO, American Physical Therapy Association;
- Stacy Sanders, Federal Policy Director, Medicare Rights Center;
- K. Eric DeJonge, President-Elect, American Academy of Home Care Medicine (AAHCM);
- Alan E. Morrison, Chair, Diagnostic Services Committee, National Association for the Support of Long Term Care (NASL);
- Christel Aprigliano, CEO, Diabetes Patient Advocacy Coalition;
- Deepak A. Kapoor, Chairman and CEO, Integrated Medical Professionals; and,
- Cletis Earle, Chairman-Elect, CHIME Board of Trustees.

III. BACKGROUND

During this hearing, the Subcommittee will discuss the following legislation:

A. H.R. 3120, to reduce the volume of future electronic health record-related significant hardship requests

The bill, sponsored by Rep. Burgess (R-TX) and Rep. Dingell (D-MI), amends the Health Information Technology for Economic and Clinical Health (HITECH) Act in order to remove a requirement that requires the Secretary of Health and Human Services (HHS) to continue to make meaningful use standards more stringent over time. While the meaningful use program has been very successful in driving adoption of electronic health records (EHRs), many providers have struggled to meet the requirements of meaningful use. As the Secretary is mandated to continue to raise the standards overtime, more and more providers are likely to fall behind. When this happens, providers will often seek a hardship waiver to acknowledge they could not meet the increased standards. This increases the burden further on HHS to process an ever increasing number of hardship requests. The bill simply removes the mandate that meaningful use standards become more stringent over time and allows the Department to be more deliberative in such evaluations.

B. H.R. 1148 Furthering Access to Stroke Telemedicine Act of 2017 (FAST Act)

This legislation, introduced by Rep. Griffith (R-VA), and Rep. Joyce (D-OH), would expand the ability of patients presenting at hospitals or at mobile stroke units to receive a Medicare reimbursed neurological consult via telemedicine, 18 months after enactment. Currently, Medicare will only pay for such a consultation if the originating site hospital is in a rural Health Professional Shortage Area or a county outside a Metropolitan Statistical Area.

C. H.R. 2465, Steve Gleason Enduring Voices Act of 2017

This legislation, introduced by Rep. McMorris Rogers (R-WA), Rep. Scalise (R-LA), and Rep. Larson (D-CT), would make coverage of speech generating devices under “routinely purchased durable medical equipment” permanent under the Medicare program. Previously, under rules issued from the Centers for Medicare and Medicaid Services (CMS) speech generating devices, which are uniquely configured for each eligible beneficiary, were categorized and covered under a capped rental payment. However, if the beneficiary entered a nursing home, hospital, or hospice, payment ended, which limited access to the device. Congress responded in 2015 by passing the Steve Gleason Act, which removed speech generating devices from the capped rental categorization. The bill would remove the 2018 sunset and make this payment category change permanent.

D. H.R. 3263, to extend the Medicare Independence at Home Medical Practice Demonstration program

The bill, sponsored by Rep. Burgess (R-TX) and Rep. Dingell (D- MI), would extend the Independence at Home Medical Practice Demonstration Program (IAH), which provides a home-based primary care benefit to high-need Medicare beneficiaries with multiple chronic conditions, ideally allowing them to avoid unnecessary hospitalizations, ER visits, and nursing home use, for two additional years. Currently in its fifth year, CMS has evaluated the program's success and found it to have saved money for the program in the first and second years (year three data is still be analyzed.) Under statute, the demonstration must generate savings and any practice that does not generate savings of 5 percent faces removal from the demonstration

E. H.R 3163, to provide for a home infusion therapy services temporary transitional payment under the Medicare program

This legislation, introduced by Rep. Tiberi (R-OH), Rep Pascrell (D-NJ), Rep. Upton (R-MI), and Rep. DeGette (D-CO), would provide a temporary transitional payment under Medicare Part B for home infusion therapy services from 2019 through 2021. Under the 21st Century Cures Act, Congress changed the Medicare program payment for home infusion medications to the average sales price +6 percent. This was intended to more accurately reflect the true costs of these medications starting in 2017. In addition, recognizing that there are unique training and educational requirements necessary to deliver the services in the home, Congress also created a new Medicare benefit for the payment of home infusion education and serves starting in 2021. This bill would bridge the gap between the underlying payment change currently effective and the new benefit in 2021.

F. H.R. 2557, Prostate Cancer Misdiagnosis Elimination Act of 2017

This legislation, introduced by Rep. Bucshon (R-IN) and Rep. Rush (D-IL),would provide for coverage of DNA Specimen Provenance Assay (DPSA) testing. Prostate cancer is diagnosed with a 10 to 12 samples needle biopsy to detect for cancerous cells, a protocol that became clinical standard in 2010 and improved the detection rates of prostate cancer.[1] However, despite rigorous lab protocols, a high rate (2.5 percent) of specimen provenance complications (SPCs) occur, where a test result is contaminated with tissue other than the patient's. As a result, approximately 1.28 percent of positive tests are in fact cancer free.[2] DPSA is a diagnostic tool that can address the chances a false diagnosis, with the potential to prevent unnecessary and costly treatment protocols. DPSA compares the DNA of the patient to the DNA of the tissue sample tested for cancer. Currently, this test is not covered under the Medicare payment program due to its classification as "quality assurance" rather than a diagnostic test.[3]

G. H.R. 3271, Protecting Access to Diabetes Supplies Act of 2017

This legislation, introduced by Rep. DeGette (D-CO) and Rep. Brooks (R-IN), addresses several issues beneficiaries have reported facing under the competitive bidding program regarding Diabetes Test Strips (DTS). The competitive bidding program has several beneficiary protections that the legislation seeks to place into statute to ensure proper oversight and

enforcement of these protections. For example, evidence has been presented that the 50 Percent Rule – established by Congress to ensure suppliers make available at least 50 percent of all types of DTS on the market before enactment of the competitive bidding program – has not been fully enforced by CMS.

H. H.R. 3245, Medicare Civil and Criminal Penalties Act

This legislation, introduced by Rep. Bilirakis (R-FL) and Rep. Castor (D-FL), would update both civil and criminal penalties in the Medicare program. Many of these penalties were last updated 20 years ago.

I. H.R. 849, Protecting Seniors' Access to Medicare Act of 2017

This legislation, introduced by Rep. Roe (R-TN) and Rep. Ruiz (D-CA), would repeal the Independent Payment Advisory Board (IPAB). The IPAB is a panel created by sections 3403 and 10320 of the Patient Protection and Affordable Care Act to recommend policies to reduce growth in Medicare spending if certain growth targets are exceeded. The IPAB is triggered when the growth rate in Medicare exceeds target growth rates, as reported by the CMS Office of the Actuary, and is responsible for recommending to Congress spending reductions in the Medicare program in order to reduce the growth of the program below the target growth rate. Because no members of the IPAB have been appointed, if the IPAB is triggered, the policies to achieve reductions in Medicare to meet target growth rates would be recommended and implemented by the Secretary for Health and Human Services.

J. Discussion Draft related to reforming mobile lab payments

The draft legislation would create a new payment methodology for laboratory services provided in nursing homes and in the home, to homebound individuals, paid under the clinical laboratory fee schedule for Medicare beneficiaries. The draft seeks to implement a new per-episode bundled payment replacing the current fees associated with furnishing the test, travel allowance, and specimen collection.

K. Discussion Draft related to Therapy Caps

Since 1997, Medicare beneficiaries have faced limits (caps) on the amount of annual per-patient therapy expenditures. In 2006, Congress created an exceptions process that allows patients to exceed this cap if medically necessary. In 2015, Congress last extended the exceptions process while instituting a new program of manual medical review to further improve program integrity.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact J.P. Paluskiewicz and Paul Edattel of the Committee staff at (202) 225-2927.