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EXAMINING BIPARTISAN LEGISLATION

TO IMPROVE THE MEDICARE PROGRAM

THURSDAY, JULY 20, 2017

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2123, Rayburn House Office Building, Hon. Michael Burgess, M.D. [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Barton, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Butterfield, Matsui, Castor, Schrader, Kennedy, Eshoo, Degette, Pallone (ex officio), and Burgess.

Staff Present: Kelly Collins, Staff Assistant; Jordan Davis,

Director of Policy and External Affairs; Daryll Dykes, Health Fellow; Paul Edattel, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Jay Gulshen, Legislative Clerk, Health; Drew McDowell, Executive Assistant; Alex Miller, Video Production Aide and Press Assistant; James Paluskiewicz, Professional Staff, Health; Jennifer Sherman, Press Secretary; Danielle Steele, Policy Coordinator, Health; Evan Viau, Staff Assistant; Jeff Carroll, Minority Staff Director; Una Lee, Minority Senior Health Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Burgess. The Subcommittee on Health will now come to order.

As a housekeeping note, there will be votes on the floor as we -- probably before we conclude opening statements. The chair advises the members that we are keeping an eye on the floor, and when the votes are called, obviously, we will consider recessing at that point to reconvene immediately after votes.

Before I recognize myself for an opening statement, I also want to acknowledge the majority counsel, this is her last hearing. We are going out with a bang with 11 witnesses today. But Danielle Steele has done a good job for us, but as they say, she is going to a better place over in the other body. But thank you, Danielle, thanks for your help on the committee.

[Applause.]

Mr. Burgess. I now recognize myself 5 minutes for an opening statement.

Today, we are going to be discussing 11 bipartisan policies lead by members of this committee. Each of these policies exemplifies our shared commitment to strengthening the Medicare program for its current beneficiaries and improving it for future generations.

I would like to thank Representative Dingell for working with me on two of the bills that we will be considering today, H.R. 3120 and H.R. 3263. I have made it a top priority to improve the value of electronic health records for providers and patients. And I believe we have made some progress through the policies enacted in the Medicare Access and CHIP Reauthorization Act of 2015, as well as the 21st Century

Cures Act of 2016. However, there is more to be done, and H.R. 3120 will continue to move us in the right direction.

Meaningful use requirements for physicians in hospitals in the Social Security Act demand that the Secretary seek to improve the use of electronic health records and health quality over time by requiring more stringent measures of meaningful use. Time has shown us that simply increasing the rigor of the standards does not improve the use of electronic health records or the quality of the healthcare delivered.

As the Secretary has mandated to continue to raise the stringency of standards over time, more and more providers would possibly fall behind. Therefore, the only clear result of increasingly stringent standards for meaningful use has been an increasing need for the Department of Health and Human Services to grant more waivers. H.R. 3120 will simply remove the mandate that meaningful use standards become more stringent over time and allow the Department to be deliberative in determining how meaningful use can improve electronic health records and the quality of care.

Over the past 5 years, the Independence at Home Demonstration program has provided Medicare beneficiaries with the unique opportunity to receive home health services that they would not otherwise have been able to access. Designed in a manner that requires home care providers to improve outcomes for patients while reducing the overall cost of care, the program continues to be a standard bearer for bipartisan collaboration in improving the delivery of care for

seniors.

H.R. 3263 would both extend the program for an additional 2 years and allow providers currently participating in the program to increase the number of patients currently under management.

I want to take a moment to speak to the two discussion drafts the subcommittee will also review today. I hope both of these drafts show that the committee is open to ideas on ways to reform the Medicare program, and is willing to put in the long-term bipartisan work necessary to fully develop these important policies. For example, reforming the payment system for the mobile collection of lab samples offers an opportunity to reduce spending and protect program integrity and to move to an episodic payment. I hope the committee will see each of these bills offers a common sense improvement to the Medicare program.

There is one draft before us I hope we will not have to act on, and that is the discussion draft of another simple extender of the therapy caps exception process. Much like the sustainable growth rate formula, we have a policy inherent to the therapy cap that no one supports, and each year, we have to find offsets in the Medicare program to simply protect beneficiaries from a policy harmful to their access to treatment. Also, like the sustainable growth rate formula, this year-by-year approach is not cost effective, does not provide needed stability for providers and patients. As we did with the repeal of the sustainable growth rate formula, it is my hope that we can find a permanent policy solution for this issue. That work should start

and be lead by this subcommittee. I hope members will examine these policies and provide feedback to the committee staff.

I do want to thank all of our witnesses for being here today. I look forward to hearing from each of you on how these bills we are considering can improve the Medicare program.

And I do want to recognize Mr. Bilirakis to speak on his bill.

[The prepared statement of Mr. Burgess follows:]

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

Mr. Bilirakis. Thank you very much, Mr. Chairman. I appreciate it so much. Thank you again for holding this hearing, and I thank the panel for their testimony.

Last week, we had the largest healthcare fraud takedown in history. 412 defendants were charged nationwide, including more than 80 cases in Florida, for Medicare fraud, totaling $1.3 billion in losses.

Medicare is absolutely critical for seniors in my district and across the country. Not only is Medicare fraud an affront to hardworking taxpayers, it hurts the millions of seniors who rely on the program. That is why I introduced, along with my fellow Floridian, Kathy Castor, much needed legislation to strengthen penalties against those who commit fraud in the Medicare program.

The Medicare Civil and Criminal Penalties Update Act, H.R. 3245, cracks down on Medicare fraud and abuse by increasing civil and criminal fines. Some of these penalties have not been updated in over 20 years. We must ensure the Medicare program is strong and sustainable for today's and tomorrow's beneficiaries.

I yield back, Mr. Chairman. Thank you.

[The prepared statement of Mr. Bilirakis follows:]

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

Mr. Burgess. The gentleman yields back. The chair yields back.

The chair now recognizes the subcommittee ranking member, Mr. Green, 5 minutes for an opening statement, please.

Mr. Green. Thank you, Mr. Chairman. And I welcome our witnesses today.

Since 1965, Medicare has provided affordable health insurance coverage and access to the care for our Nation's seniors in most vulnerable populations. Few programs have improved the lives of Americans as significantly as Medicaid and Medicare. Fifty years ago, almost half of elderly Americans lacked health insurance, and now Medicare provides lifesaving insurance to nearly 100 percent of the adults over 65.

Today, we are examining 11 bipartisan bills that aim to improve the Medicare program, particularly Medicare part B, which covers physician, outpatient, laboratory, and some home health services, as well as durable medical equipment.

One of the discussions we are actually considering will extend the therapy cap exceptions process. I have long supported repealing the therapy caps, which was enacted in 1997, and harm some of the most vulnerable beneficiaries. I support extending the exceptions process at the very least, but I also want to be sure that all the extenders that are included in the Medicare Access and CHIP Reauthorization Act, MACRA, are set to expire at the end of the fiscal year or calendar year, are addressed in a timely fashion.

Another bill we are considering is H.R. 1148, the Furthering

Access to Stroke Telemedicine, or FAST Act, is worthy of our support. The bill will expand Medicare reimbursement for providers for stroke telemedicine services beyond those provided in rural areas. Telemedicine, in general, holds great promise to improve patient care and lower costs, and I am pleased to be part of the bipartisan telemedicine working group. Telestroke, in particular, can be critical service to patients who need access to a stroke specialist as soon as possible after an event.

H.R. 849, the Protecting Seniors' Access to Medicare Act, will repeal the Independent Payment Advisory Board, the IPAB. While the recent Medicare Trustees' report concluded that the IPAB recommendation process wouldn't be triggered this year, it is still important that Congress move to repeal this ill-conceived board. We should not be outsourcing our responsibility to manage and oversee the Medicare program. I opposed the IPAB when it was debated during the crafting of the Affordable Care Act, and it wasn't part of our bill when we passed it in the House, and strongly support its repeal.

H.R. 3163, the Medicare Part B Home Infusion Services Temporary Transitional Payment Act, is another bill worthy of our support. It will provide temporary transitional payment for home infusion therapy under Medicare. The overpayment of the home infusion drugs was addressed in the 21st Century Cures, but the timing payment changes for drugs and services associated with their administration do not line up, potentially resulting in reduction of patient access. This bill fixes the problem by providing a temporary bridge from 2019 to 2021,

so patients who need home infusion therapy don't unduly lose access to the care they need.

I also want to highlight H.R. 3271, Protecting Access to Diabetes Supplies Act. The bill would make improvements to Medicare's competitive bidding program for diabetes testing strips by strengthening patient protections and enhancing beneficiary choice. It would require CMS to enforce the requirement that suppliers provide at least 50 percent of all diabetes test supplies that are commercially available before implementing a competitive bidding program, provide suppliers from -- prevent suppliers from coercing beneficiaries into changing their choice of test strips, and make it easier for patients to switch and receive different testing supplies if they want to. I have cosponsored this legislation in the past, and I will continue to support it.

H.R. 2465, the Steve Gleason Enduring Voices Act, will permanently get rid of the durable medical equipment rental cap for speech generation -- generating devices. SGDs are exempt from the rental cap until October 1 of 2018. This bill would make the policy permanent. We should ensure beneficiaries who rely on SGDs have the access to their necessary and personalized communication technology, even if they reside in a nursing home or are hospitalized or in a hospice.

Mr. Chairman, all 11 bills are bipartisan, and will improve Medicare providing -- participating providers, and more importantly, care for our beneficiaries. I look forward to hearing from these folks

and I yield back the balance of my time.

[The prepared statement of Mr. Green follows:]

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Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the chairman of the full committee, Mr. Walden of Oregon, 5 minutes for an opening statement, please.

The Chairman. Thank you. Thank you very much, Mr. Chairman. Thanks for holding this hearing.

As we have heard, we are going to look at 11 bipartisan bills today as part of reforms to Medicare part B. Each of these have been championed by different members on this subcommittee. We care deeply about them. We look forward to your testimony.

Together, we seek to improve the care delivered to our Nation's seniors who rely on the Medicare program, whether that is by allowing them to stay in their homes and seek care through home infusion or receiving home call visits or the Independence at Home program.

We want to improve these programs. We want to improve the integrity of them. We want to look at the vulnerabilities and the current laboratory fee schedule. We want to update the criminal and civil monetary penalties associated with Medicare fraud. You know, fundamentally, no crook should ever be less afraid of defrauding the Medicare program or taking advantage of a beneficiary simple because the penalties haven't been updated in decades. We need to make those penalties have teeth. And when we have an extremely successful program like competitive bidding, which has saved Medicare and its beneficiaries billions of dollars, proper oversight work of our committee should not stop. I always believe in oversight. I think

it is important for programs that we pass, to make sure that they are being implemented appropriately, and for programs that have been there a long time, to make sure that they are working for the people they are intended to serve.

Today, we will also seek to use the ability of providers to deliver care by allowing CMS flexibility in setting goals for meaningful use and discuss the permanent solution of the arbitrary cap on therapy services. I have heard about that from time to time. No doctor should be forced to counsel a patient to choose surgery over therapy because they might otherwise run out of therapy services.

Finally, there are times when the current Medicare rules just don't make sense. For example, Medicare would take away the ability of a beneficiary to speak when their care setting changes. A time when communication is most important. Or Medicare's current policy that pays for the debilitating impact of a stroke and the long-term care services that follow in the Medicaid program, instead of paying a trained neurologist to examine a patient, providing a telestroke consult, and potentially avoiding the cost and the disability altogether.

So I think all of these are common sense fixes. I believe my colleagues here would agree with that. It is more good work by this committee and by those of you who have brought these issues to our attention.

We will also address the Independent Payment Advisory Board. While the Medicare Trustees have given us some added time, we should

not delay abolishing this expropriation of congressional authority over the Medicare program.

Finally, I want to thank Mr. Pallone and Mr. Green for their willingness to work with us on all of these efforts, and particularly, to begin the hard but necessary conversations surrounding a permanent policy on the therapy caps. Our committee has a long history of taking on these lingering problems and dealing with them by working together, and we have proven that this year, again, on a lot of different legislative fronts, and I look forward to continuing to do so.

So, again, thanks to our witnesses for being here. And with that, I know Mrs. McMorris Rodgers wanted time, if she is able to get here from her leadership meeting, but between now and then, I would yield the balance to my friend and colleague from Tennessee, Mrs. Blackburn.

[The prepared statement of Chairman Walden follows:]

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

Mrs. Blackburn. And I thank the chairman for yielding. And, Mr. Chairman, I thank you for this hearing. The topic is timely, as you can see, by the panel that is in front of us. You all look more like a football team up there ready to go to the game. And we are going to focus on a few areas.

I have 19 counties in my district, 16 of which are rural. So looking at what we do with rural access is something that is going to be very important to me. And as the chairman outlined some of the changes that are in front of us, increasing that access to rural providers is going to be important. Rescinding flawed systems that really are doing harm rather than increasing access, we will want to focus on that, and then program integrity. I think you cannot underestimate that. It is important, not only to us, but to the providers, and there are questions that we are going to have for each of you. So welcome. Many of you have been before us before, so we appreciate the continued conversation.

And, Mr. Chairman, I will yield back to the chairman.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman.

Today, we will examine 11 bipartisan bills aimed at improving care in the Medicare program. Medicare plays a critical role in the lives of our Nation's seniors and disabled Americans, and it is so important that this committee continue to look for ways to strengthen the program and deliver the highest quality care to beneficiaries. And I commend the chairman for holding this hearing. I look forward to working with you on these measures as we move forward.

First, I want to say I am pleased that we will be discussing H.R. 1148, the FAST Act, introduced by Representatives Joyce and Griffith. When it comes to stroke, every second counts. Stroke telemedicine, also known as telestroke, breaks down barriers to care, and is a valuable tool for combatting our Nation's fifth leading cause of death.

The FAST Act would expand coverage of telestroke services in the Medicare program so that beneficiaries can get the right treatment at the right time, no matter where they live. I look forward to hearing from Dr. Kissela today about the impact of expanding telestroke services in the Medicare program.

Additionally, I am pleased that we have a discussion draft on extending the exceptions process and targeted manual medical review

for physical therapy caps. It is long past overdue for us to have a serious discussion about a permanent policy to address these caps. In MACRA, we instructed CMS to eliminate manual medical review for all claims above the $3,700 threshold, and instead put in place a targeted less burdensome review. I understand that this process is working quite well for both beneficiaries and providers, and I look forward to hearing from the American Physical Therapy Association today about how targeted medical review can be part of a long-term solution that both preserves access for beneficiaries and reduces the burden on providers.

I also look forward to hearing from the National Home Infusion Association about H.R. 3163. Home infusion is a critically important service that allows Medicare beneficiaries to receive infusion drugs at home, rather than other more expensive and less convenient sites of care. I support H.R. 3163, and I am glad that we have been able to work on a bipartisan basis on this important bill to ensure continued patient access to these important drugs at home.

I also look forward to hearing from our witnesses on the other six bills and the discussion draft on mobile laboratories. All of these bills aim to make meaningful changes to the Medicare program by protecting beneficiaries, reducing provider burden, improving program integrity, or delivering comprehensive primary care services to Medicare beneficiaries in their home. And I look forward to learning more about these bills and working on a bipartisan basis to advance these efforts.

And, finally, H.R. 849, introduced by Representatives Ruiz and Roe. This would repeal the Independent Payment Advisory Board, or IPAB. This is not the first time we have considered repealing IPAB. As I have said in the past, I am opposed to IPAB and would be in favor of abolishing it. However, unlike the past, I hope we can work in a bipartisan fashion to eliminate IPAB. It is my belief that Congress should not be ceding legislative authority to independent commissions like IPAB by allowing them to play more than an informational role.

The Affordable Care Act strengthened the Medicare program and put it on the pad towards incentivizing value over volume. It lengthened the life of the Medicare trust fund and contributed to a lower rate of growth of Medicare expenditures. It is our job as legislators to continue this work to ensure that the program remains strong for future generations. It is not the job of an unelected commission.

So I look forward to learning more from our witnesses about all the policies up for discussion today. And unless someone else wants my time -- I don't think so. I will yield back the balance of my time.

[The prepared statement of Mr. Pallone follows:]

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Mrs. McMorris Rodgers. Would the gentleman yield.

Mr. Pallone. I am sorry. What?

Mrs. McMorris Rodgers. Would the gentleman yield?

Mr. Pallone. Oh, you want my time? Sure.

Mrs. McMorris Rodgers. Could I, please? Thank you. Thank you. A little bipartisanship going on. I promise not to say anything that offends you too much.

Thank you, Ranking Member Pallone, and everyone on the committee. In 2014, I heard from a concerned mom in my district, Gail Gleason, who told me a story about her son, Steve. Born and raised in Spokane, Washington, Steve was a college football and NFL star before being diagnosed with ALS in 2011. Gail was afraid outdated and practical Medicare payment regulations were preventing people like Steve from accessing critical technology, individualized speech generating devices. She was right.

Under the rules issued by CMS, these speech generating devices were categorized and covered under a capped rental payment. However, if an individual was admitted to a nursing home, hospital, or hospice, payment abruptly ended, leading to severe access issues. To fix this, we introduced the Steve Gleason Act in 2015, which required Medicare to cover these devices as routinely purchased medical equipment. This allowed patients to continue communicating with their doctors, their caregivers, and their loved ones using this cutting edge technology, regardless of where they were being treated. Thanks to a great deal of hard work right here in this committee, it became law later that

year.

But we could only provide the relief for 2 years. The law is scheduled to sunset in 2018. This is why my legislation, which we will be discussing today, is so important. The Steve Gleason Enduring Voices Act makes the changes accomplished in the original Steve Gleason Act permanent. Without a permanent solution, the short-sided policy decisions previously made by CMS could again limit the ability of thousands of men and women living with these degenerative diseases to access their only means of communication, to tell their husbands, their wives, their children, that they love them.

The Steve Gleason Enduring Voices Act gives a permanent voice to the voiceless. And as Steve Gleason says, it ensures there are no white flags.

Thank you, and I yield back.

[The prepared statement of Mrs. McMorris Rodgers follows:]

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Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

This concludes with member opening statements. The chair would like to remind members that, pursuant to committee rules, all members' opening statements will be made part of the record.

The floor is still in amendment debate, so we want to thank our witnesses for being here today, for taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by questions from members.

Today, we are going to hear from Ms. Christel Aprigliano, CEO of the Diabetes Patient Advocacy Coalition; Dr. Brett Kissela, professor of neurology, chair, Department of Neurology and Rehabilitation Medicine, University of Cincinnati Gardner Neuroscience Institute, on behalf of the American Academy of Neurology; Ms. Lisa Bardach, speech-language pathologist, ALS of Michigan; Dr. Varner Richards, board chair, National Home Infusion Association; Ms. Mary Grealy, president, Healthcare Leadership Council; Dr. Justin Moore, CEO, American Physical Therapy Association; Ms. Stacy Sanders, federal policy director, Medicare Rights Center; Dr. Eric De Jonge, president-elect, American Academy of Home Care Medicine; Mr. Alan E. Morrison, chair, Diagnostic Services Committee, National Association for the Support of Long Term Care; Dr. Deepak Kapoor, chairman and CEO, Integrated Medical Professionals; Mr. Cletis Earle, chairman-elect of the Board of Trustees of CHIME.

We appreciate all of you being here today. And Ms. Aprigliano,

you are now recognized for 5 minutes to summarize your opening statement, please.

STATEMENTS OF CHRISTEL APRIGLIANO, CEO, DIABETES PATIENT ADVOCACY COALITION; BRETT KISSELA, PROFESSOR OF NEUROLOGY, CHAIR, DEPARTMENT OF NEUROLOGY AND REHABILITATION MEDICINE, UNIVERSITY OF CINCINNATI GARDNER NEUROSCIENCE INSTITUTION, 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 DE JONGE, 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); DEEPAK A. KAPOOR, CHAIRMAN AND CEO, INTEGRATED MEDICAL PROFESSIONALS; AND CLETIS EARLE, CHAIRMAN-ELECT, CHIME BOARD OF TRUSTEES

STATEMENT OF CHRISTEL APRIGLIANO

Ms. Aprigliano. Thank you.

Good morning, Chairman Burgess, Ranking Member Green, and members of the subcommittee. My name is Christel Marchand Aprigliano, and I am speaking to you today as the CEO of the Diabetes Patient Advocacy Coalition and as a person with diabetes. I am delighted to be here today to talk with you about and urge you to enact 3271.

Today, more than 30.3 million Americans are known to have

diabetes, with an estimated 84.1 million diagnosed with prediabetes. According to CDC calculations, 1 in 3 Americans will have diabetes by 2050. And we are on the cusp of a severe health crisis.

The cost of this disease's well-known debilitating complications, including heart disease, blindness, nerve damage, kidney damage, and amputations, are common among people with mismanaged diabetes, and are associated with extraordinary consumption of health services. The Medicare program bears much of this financial burden. It is also well-known that the tight blood glucose control can reduce the risk of these developing complications.

Medicare's competitive bidding program, while saving money on diabetes testing products, may be hindering the ability to achieve this important control and causing problems that lead to higher costs elsewhere within the program. Diabetes testing supplies -- blood glucose monitors, test strips, lancets, et cetera -- were included in the first rounds of CBP. Before the CBP, Medicare paid between $34 and $38 for a box of 50 test strips. Today, Medicare pays $8.32 for a box of 50 test strips. For beneficiaries, this remarkable savings makes it easier to afford supplies, and I applaud you for that.

But, while the lower price yields substantial immediate savings, it comes at a cost for beneficiaries and for the program elsewhere. Since implementation of the national mail order CBP in 2013, Congress has seen reports indicating that beneficiary access to diabetes testing supplies has dropped significantly.

Recent studies by the IG for the Department of Health and Human

Services show that the most commonly prescribed testing systems, before implementation of the CBP, are now no longer available via mail order. Why? Under the CBP, suppliers are paid the same amount by Medicare for diabetes testing supplies, regardless of which brand they offer. Medicare is incentivizing suppliers only to offer the least costly supplies available.

I have heard from beneficiaries who report suppliers trying to switch them to a different blood glucose monitor, presumably because those systems are cheaper for the supplier. The beneficiary is switched to an unfamiliar meter and despite the antiswitching protections. These are not the meters that they have been recommended and trained on by health professionals.

When a patient, particularly an older patient, is given an unfamiliar technology, they may not be nimble enough to make the transition. They can get frustrated and stop testing. Unfortunately, on top of that, if that testing system is of inferior qualify, as they too often are, the threat to regular and accurate testing is even greater. A recent study by the Diabetes Technology Society brings to light the consequences of this incentive.

The data shows that more than 60 percent of the strips furnished to beneficiaries between October and December of 2016, failed the study's accuracy standards, which are the FDA's accuracy standards. In other words, more than half the systems paid for by Medicare during the last quarter of 2016 can't be relied on to produce accurate and consistent blood glucose readings, according to the study's standard.

Insulin and oral medications are lifesaving, but they can also be harmful, even fatal when misdosed. Inaccurate blood glucose readings can cause overdoses and underdoses of insulin or oral medications, sending people to the ER and costly hospitalization stays.

If the majority of test systems furnished to beneficiaries can no longer be relied upon to produce accurate results, we are no longer on the cusp of the public health crisis we see. We are in the midst of it, and Medicare is going to bear the financial brunt.

I am not here today advocating for Congress to eliminate the CBP. Policy behind Medicare's competitive bidding program is sound, shouldn't be abandoned. I do, however, believe it can and should be improved to ensure the safety of people with diabetes.

There are a number of steps that Congress should take to address these concerns. H.R. 3271 is a step in the right direction. Congress and CMS establish beneficiary protections, like the 50 percent and antiswitching rules, to prevent the shift in product access and deterioration in product quality. Nonetheless, these protections clearly are not properly implemented and also not sufficient. H.R. 3271 would strengthen these existing patient protections and establish new ones to better protect Medicare beneficiaries.

As a person living with diabetes since 1983, I rely on access to accurate blood glucose testing systems to mitigate both short- and long-term complications. For the more than 8 million Medicare beneficiaries in my diabetes community, I respectfully urge you to enact H.R. 3271 to ensure access to these blood glucose monitoring

systems.

Thank you for the honor and the opportunity to speak with you today. I am delighted to answer any of your questions.

[The prepared statement of Ms. Aprigliano follows:]

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Mr. Burgess. The chair thanks the gentlelady for your testimony. Dr. Kissela, you are recognized for 5 minutes, please.

STATEMENT OF BRETT KISSELA

Dr. Kissela. Chairman Burgess, Ranking Member Green, and others members of the committee, thank you for the opportunity to testify today on behalf the American Academy of Neurology about the FAST Act of 2017, the Furthering Access to Stroke Telemedicine Act.

I am a stroke neurologist. And as a neurologist, I care for many neurologic diseases, and I am very supportive of the bills that are being presented here today, many of which affect neurologic patients. But I have extra training and expertise in vascular problems of the brain, the most common of which is stroke.

I am going to focus today on ischemic stroke, which is 90 percent of all strokes, and that occurs when a blood clot blocks one of the arteries going to the brain so that the downstream tissue is not getting the blood with the oxygen that it needs to survive. And that brain tissue is, in a sense, dying, suffocating, I tell patients, if we can't do something about it. Luckily, we can do something about it.

We have very successful treatments that we can implement in a short timeframe after the stroke starts. We have the clot-busting drug, tPA, or alteplase, that can be given by a vein, and break open the blood clot and restore flow, sending people home normal who otherwise might be disabled. And we have catheter-based treatment for

the largest strokes, which we have just literally learned how to use effectively in the last few years, to handle the most disabled people who would otherwise be impaired by stroke.

What we have learned over the years with our new treatments is that time is brain. Every minute counts. If we waste time and have delays, we will have worse outcomes. In fact, if we can shorten the time from stroke onset to treatment by 15 minutes, an additional 5 percent of patients will go home normal, as opposed to being disabled by their stroke. So time is brain.

Telestroke is a form of telemedicine that we use to do acute stroke evaluations, and it is a tool that saves lives and will ultimately save money by improving the outcome for our stroke patients.

I work in Cincinnati, and I will tell you about a typical night on call. We have a very unusual situation in our city where we have a stroke team that serves the entire region, 27 hospitals, that are not only in the greater metropolitan area of Cincinnati, which includes southeastern Ohio, but also parts of Indiana and northern Kentucky. And when there is a stroke at one of those hospitals, they give us a call, and we try and offer our therapy.

When I started 20 years ago, we only had phone calls. We would take the information as best we could, try and make a good decision. If it was at a local hospital, we would drive out and make a good decision by evaluating the patient, but that wasted valuable time. Now we have telestroke. We started with our outlying hospitals, and now we are doing it throughout the entire region, because this is the right thing

to do. It saves time and saves brain and improves the outcome.

Ninety-four percent of all strokes happen in urban and suburban areas, not in rural areas. And therefore, we would like to provide Medicare reimbursement for telestroke to all stroke patients.

One of my stroke calls recently was a Saturday night. This is how I spend my Saturday nights. I was treating a patient who had a large stroke, a health teacher from northern Kentucky, who we were able to take his clot out and save him from a lifetime of disability, and he is teaching junior high students about stroke.

In the middle of that case, another call came in from, in fact, a 35-year-old mother of two. Her husband is an EMT, so he saves lives every day by bringing people in on the ambulance, and we were called to try and save his wife, who he knew very well was having a stroke. By telemedicine, I was able to evaluate her quickly, make the right decision, and we saved her from being paralyzed on the right and unable to speak to now being able to be fully normal, taking care of her family, and telling her children that she loves them. They also run a charity in Haiti, and they are helping poor people there. Thankfully, this woman can still do that. And that is the power of telestroke.

Telestroke will save money. It has been estimated by the American Heart and Stroke Association, that the FAST Act could save the healthcare system as much as $1.2 billion over the next 10 years, if approved. The cost of stroke is all on the downstream time. When someone is disabled by stroke and has to live in a care facility, that is what the true expense is. Telestroke can mitigate this cost. One

study of cost utility of telestroke networks estimated that by implementing across an entire region, more than $1,400 per patient could be saved, even after accounting for the cost of implementing the network and administering additional treatments.

The standard of care of stroke has changed, and we have improved our ability to treat this devastating disease. And now we have a new tool that can help us do it faster and better and save money. I would urge that the FAST Act be approved in that we have a new standard of care, and the reimbursement model should align with that standard of care to incentivize people to set up telestroke in all parts of this country and treat all Americans with stroke.

Thank you for your attention to stroke, which is a terrible disease that I am very passionate about treating. On behalf of the American Academy of Neurology, I greatly appreciate the thought and deliberations that went into the development of this bill, as well as the opportunity to express our strong support at today's hearing. Thank you.

[The prepared statement of Dr. Kissela follows:]

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

Mr. Burgess. Thank you, Doctor. Thank you for your testimony.

Ms. Bardach, you are recognized for 5 minutes for your opening statement, please.

STATEMENT OF LISA BARDACH

Ms. Bardach. Imagine that you have suffered a severe stroke or that you are living with ALS. You have been robbed of your ability to speak and write. You no longer have control over your body. You are completely aware of your surroundings and you understand everything that is happening to you. Your son comes home from high school and announces that he has just been elected class president. You are so proud, but you cannot tell him this. Later that evening, as your wife helps you get ready for bed, you want to tell her how much you love her. You want to tell her how proud you are of the children that you have raised, but you cannot do this.

Communication devices help people talk. This is how individuals participate in the myriad of communication opportunities that arise every day.

My name is Lisa Bardach, and I am the speech-language pathologist at ALS of Michigan. I am also the owner of a private practice called Communicating Solutions, in Michigan, that provides evaluation and treatment for people who need communication devices. And I am here on behalf of Team Gleason as well. But mostly, I am here on behalf of everybody in the United States who needs a communication device in

order to be able to speak.

People who are unable to communicate verbally use communication devices, also known as speech generating devices, or SGDs. These are electronic means of communication, and a person uses them to speak by accessing stored messages or by creating new utterances using pictures, words, text, spelling, or any combination thereof. I am here to ask you to support the Steve Gleason Enduring Voices Act of 2017, H.R. 2465.

Steve Gleason, a former NFL player who is living with ALS, has provided a tremendous amount of support and inspiration for people across the country. But ALS only represents a small percentage of people who need communication devices. Individuals with multiple sclerosis, Parkinson's disease, stroke, cerebral palsy, traumatic brain injury, autism, and quite a number of other conditions require communication devices.

Communication devices have been a covered benefit under Medicare since 2001. The Steve Gleason Enduring Voices Act of 2017 permanently reinstates communication devices into the payment category that they were originally determined under the national coverage decision in 2001. And it also ensures that users will have access to the necessary and personalized communication technology, regardless of their setting. So if they have to leave their home to go to a nursing home or a hospice or a hospital, they can take their technology with them.

In 2001, CMS put these devices under the category of frequently purchased, meaning Medicare paid one lump sum and the beneficiary owned the device, and, therefore, if he or she changed residences, that

communication technology could go with him. In 2014, these devices were placed in the category as capped rental. Make no mistake about it, Medicare still covered these devices, but the payment was amortized over 13 months in the rental period, and, therefore, if at any point during that rental period the beneficiary had to change residences, they couldn't take their technology with them because Medicare stopped paying for it. This resulted in patients delaying necessary and critical services. It resulted in them being afraid that they would have to relinquish their devices at the most vulnerable time in their lives. It resulted in people dying without being able to tell the people around them that they loved them.

I would like to share with you the words of Diane, who is a stroke survivor. She had a brain stem stroke at age 22. She says: I am writing this to you with the help of my mother who is writing down words I want to say from nodding my head to the alphabet. This is very time consuming and tedious for both of us. It seems like forever that my device has been in repair, and I am miserable without it.

Deanna is a person living with ALS. She came to me for a communication device in late 2014 when capped rental was in place. She was deathly afraid that she would lose the device if she got it funded under Medicare. Team Gleason purchased that device and amount for her. She continues to use it to this day. She wrote to me last night: I have complete peace of mind, as does my husband, that if I were to be hospitalized, my device would remain active. I can be fully independent in conveying my thoughts and desired actions in what may

be my most critical time.

Losing a voice under capped rental has an impact that is absolutely incalculable. No one knows if or when their situation will change. The only way to keep a personally configured communication device with the individual who needs it at all times is upfront purchase. While the consequences of capped rental were unintended, they were deadly.

I would like to end by sharing a note that I received from the family of one ALS patient 1 week after she died. It said: Dear Lisa, Debbie's last words were spoken on the ALS eye gazer, communication device, 2 hours before she passed. Love you all. That included you and the ALS staff, I am sure. Thanks.

Please help ensure that patients who cannot speak have unrestricted access to the communication devices they require and pass the Steve Gleason Enduring Voices Act of 2017.

[The prepared statement of Ms. Bardach follows:]

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

Mr. Burgess. The chair thanks the gentlelady for her testimony.

Dr. Richards, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF VARNER RICHARDS

Dr. Richards. Subcommittee Chair Burgess, Subcommittee Ranking Member Green, and members of the subcommittee, thank you for inviting me to share the National Home Infusion Association's, which I will refer as NHIA in the further part of my discussion, insights on H.R. 3163, the Medicare Part B Home Infusion Services Temporary Transitional Payment Act.

My name is Varner Richards, and I serve as the chair of the NHIA board of directors. NHIA is a trade association that represents providers of home infusion therapy and other companies that supply and otherwise support the delivery of infusion therapy in a patient's home. I am also the owner and CEO of Intramed Plus, Inc., a home infusion provider in the State of South Carolina. We provide services statewide to patients in South Carolina and border counties of North Carolina from three home infusion pharmacies in Columbia, Greenville, and in Charleston. I am also a clinician. I have been directly involved with providing infusion services for patients in their homes for over 30 years.

Home infusion is basically defined as a medication being infused through a needle or catheter in a patient in their home setting. It

is usually prescribed for patients where their conditions cannot be treated effectively by oral medications. Typically, the infusion therapy means the drug is administered intravenously, but can also be subcutaneously for certain therapies, which is an infusion under the skin.

Under Medicare Part B DME home infusion coverage, there is a limited number of drugs which cover a very small patient population. This small population, even though these patients suffer from life-threatening illnesses, which include cancer, cancer-related pain, viral, fungal infections, immune deficiency, and end stage of congestive heart failure. For our discussions today, I am focused on the Medicare Part B DME infusion coverage. Medicare Part B provides coverage under the durable medical equipment benefit for a limited set of home infusion therapies.

Before the passage of 21st Century Cures Act, the program specifically covered drug, pump, and supplies. There was no coverage for home infusion professional services. The available drug margin subsidizes payments for some of the home infusion professional services. With the passage of the 21st Century Cures Act, the Medicare B coverage had two important changes.

First, the drug reimbursement methodology, which changes in the average sales price to align with drug payment with the way physicians receive -- offices were currently reimbursed. This eliminated any drug margin to subsidize clinical services, and it became effective January 1, 2017.

Secondly, a professional clinical service fee was added to cover the clinical services for these patients' therapies, and that was excellent. The difficulty was scheduled to take effect in 2021. We applaud the committee with this addition of this important professional fee to ensure these patients received effective care in their own home.

The gap of 4 years between these two implementation dates of these provisions needed to be addressed in order to preserve access to these medications for home infusion patients until 2021. Last year, members of this committee pledged to resolve this issue this year.

We thank the committee for your commitments to work on this gap transition issue, and that is why we are here today. The Medicare Part B Home Infusion Services Temporary Transitional Payment Act, H.R. 3163, was introduced on July 6, and provisions from this bill was included in H.R. 3178, which was recently marked up by the Ways and Means Committee. NHIA knows that the legislation marked up by the Ways and Means Committee included technical corrections to H.R. 3163, and that this committee supports those technical corrections as does NHIA.

The bill will allow the most vulnerable of patients to continue to have access to lifesaving home infusion therapy. This legislation will create a temporary transitional payment beginning January 1, 2019, the professional services related to part B, DME infusion drugs. NHIA supports H.R. 3163 and urges passage of the bill.

While we are discussing part B home infusion drugs, I would be remiss if I did not note that most infusion drugs are covered by Medicare part D. Medicare part D reimburses providers for drug and drug only.

It does not cover the specialized infusion-related services and equipment and supplies. NHIA has and continues to seek and fix this issue as part of the Medicare Home Infusion Site of Care Act. Congressman Eliot Engel has been a long-time champion of this legislation, as you know, with Congressman Pat Tiberi of the Ways and Means Committee.

Thanks to the committee and your staff for the hard work to get this legislation prepared for the consideration today. NHIA knows that the legislation is very technical in nature, and we commend all who are involved in this effort.

Thank you for your time today, and please accept NHIA's support, the home infusion community's support, my company's personal support, and all Medicare beneficiaries who benefit from this in support of H.R. 3163. Thank you.

[The prepared statement of Dr. Richards follows:]

******** INSERT 1-4 ********

Mr. Burgess. The chair thanks the gentleman.

Ms. Grealy, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF MARY GREALY

Ms. Grealy. Chairman Burgess, Ranking Member Green, members of the committee, thank you for the opportunity to testify this morning.

I am speaking today on behalf of the members of the Healthcare Leadership Council, comprised of chief executives of innovative companies representing every sector of American healthcare.

One of HLC's foremost priorities is the attainment of a strong, sustainable, and patient-centered Medicare. And so we applaud the committee for your focus on bipartisan solutions to improve the program. We believe an initial and critical step in making Medicare stronger is to remove an entity that threatens to seriously weaken it.

The Independent Payment Advisory Board, or IPAB, was created with the ostensible purpose of controlling Medicare spending. But it does so in a way that does not improve the health of Medicare beneficiaries. It does not add value to the Medicare program, and does not respect the prerogative of the elected members of the legislative branch to set Medicare policy.

The Medicare Trustees report released last week, as we all know, did not project Medicare spending levels that triggered IPAB into action this year. We are fortunate that that has not yet occurred.

Even though neither President Obama nor President Trump has nominated members to the board, the Secretary of Health and Human Services still has the legal responsibility to initiate the process. That would almost certainly lead to arbitrary cuts in what Medicare pays for healthcare services.

Now, when that process inevitably occurs with its resulting cuts to Medicare, we know that the gap between what private insurance pays physicians to treat patients and what Medicare pays will continue to widen. And this will lead to a future in which an expanding Medicare beneficiary population will have much greater difficulty finding a physician. Even today, two of my personal physicians in Maryland have posted notices in their waiting rooms saying that they are no longer taking new Medicare patients. IPAB, if implemented, will worsen this access problem.

Nearly 800 organizations representing patients, healthcare providers, seniors, employers, veterans, Americans with disabilities, and others, are asking Congress to do away with the Independent Payment Advisory Board before harm is done to Medicare beneficiaries. Fortunately, there is bipartisan legislation pending before Congress to do just that.

H.R. 849, the Protecting Seniors' Access to Medicare Act, sponsored by Representatives Phil Roe and Raul Ruiz, is being cosponsored by a majority of the House. It should also be noted that similar legislation has been introduced in the Senate, and that a majority of that body has cosponsored one or more of the repeal bills

and resolutions that are under consideration.

But I want to call your attention to the joint resolution, H.J. Res. 51, which Congressman Roe and Ruiz have also introduced. There is an unusual provision in the IPAB authorizing legislation that allows both Houses of Congress to enact a joint resolution by August 15, 2017, which would eliminate the IPAB threat once and for all. This joint resolution would be fast tracked with no amendments and no filibuster allowed in the Senate. We strongly urge lawmakers to take advantage of this one-time opportunity that was written in to the original law.

Steps do, of course, need to be taken to make Medicare a more value-focused program, to be a more effective combatant against rising rates of chronic disease, to save money in the long run by helping beneficiaries become healthier and lessen their need for hospitalizations and emergency room visits.

Today, you are considering bipartisan legislation that will do just that. IPAB with its rapid and indiscriminate approach to healthcare spending cuts will not.

We also believe very strongly that Medicare decision-making should be in the hands of the public's elected representatives. It does not matter if a future Independent Payment Advisory Board is filled with imminently qualified appointees. It also does not matter if, in lieu of a board, that power rests with a Democratic or Republican HHS Secretary. What does matter and what should be opposed is the idea of moving Medicare policy making farther away from the millions of Americans who will feel the impact of these changes.

Congress has shown repeatedly, and most recently through the MACRA legislation from this committee, that it will act in a bipartisan fashion to improve healthcare for Medicare beneficiaries. And it is with Congress that this authority should remain.

Thank you again for this opportunity to testify, and I look forward to your questions.

[The prepared statement of Ms. Grealy follows:]

******** INSERT 1-5 ********

Mr. Burgess. The chair thanks the gentlelady for her testimony.

Dr. Moore, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF JUSTIN MOORE

Dr. Moore. Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, my name is Justin Moore, CEO of the American Physical Therapy Association. On behalf of the American Occupational Therapy Association, the American Speech-Language-Hearing Association, and APTA, thank you for this opportunity to provide testimony on bipartisan legislation to strengthen and improve the Medicare program.

Today, I will outline our shared perspective on the exceptions process to the therapy caps set to expire at the end of this year.

Without action, Medicare will impose financial limitations on outpatient physical therapy and speech-language pathology and occupational therapy services under Medicare part B. These therapy caps create an arbitrary barrier for Americans who are in need of rehabilitation services.

For 20 years, Congress and this committee have provided relief to this barrier through moratoriums and, more recently, the exceptions process, which is currently under consideration for yet another extension.

Today, we ask Congress to finally address this issue by repealing

the therapy caps once and for all. We would like to thank Representatives Blackburn and Matsui from this committee, Representatives Paulson and Kind, for championing the repeal of therapy cap legislation by introducing H.R. 807, which currently has 177 cosponsors in the House.

This pattern of yearly extensions, without a permanent solution, creates uncertainly for beneficiaries and providers, threatens access to care, and is not in the best interest of patients, providers, or the Medicare program. We recognize and appreciate that the cost of any permanent fix -- there is a cost to any permanent fix. However, the price of solving this problem will only continue to rise. With the money spent on these temporary patches over the past 2 decades, we could easily have paid for a more permanent solution.

ASHA, APTA, and AOTA have been effective partners with Congress, this committee, and CMS on this policy over the past 20 years. We have made significant reforms to preserve the integrity of the Medicare program, while simultaneously preserving access to -- for beneficiaries. We believe it is time for Congress to finally repeal the therapy caps and replace them with a thoughtful medical review process that is more targeted, ensures that care is delivered to vulnerable patients, streamlines the ability of providers to deliver that care, and ensures the long-term viability of the Medicare program. Such a policy should build upon the lessons learned, the multiple reports, and the data gathered through the current exceptions process, as well as the current and previous medical review programs.

Representatives from the three therapy groups have been in discussions with this committee about ideas for a permanent solution. Data shows that the $3,700 threshold and current medical review process is providing appropriate oversight of therapy spending, and could be improved and incorporated into a permanent solution to ensure the continuum of care and decrease administrative burdens. This policy per form, coupled with a pathway for therapy providers to be part of value-based models, will better align therapy services with the transition of Medicare to performance-based models.

To that end, we respectfully propose three principles for a permanent fix. First, ensuring patient access. Any permanent cap policy should, at its core, ensure patient access to outpatient therapy services without unnecessary delays. The fundamental flaw in the therapy caps is that it is a barrier that does not take into account the individual needs of the patient.

Principle two is a targeted approach to oversight of outpatient therapy spending. We support a mechanism to ensure appropriate delivery and utilization of outpatient therapy services. This can include targeted medical review of therapy providers whose claims exceed the $3,700 threshold and who have been identified based on specific criteria for additional review. However, such oversight should include protections for patients and ensure care is not delayed. Blanket mechanisms, such as the original therapy cap, or broad application of prior authorization, are not effective, restrict access, and interrupt the continuum of care.

Principle three is the alignment with value-based and performance-based models. We believe therapy services provided in a qualified alternative payment model should be exempt. Providers that participate in APMs would already be subject to quality and outcome requirements, as well as shared risk for the cost of care. In addition, therapy providers are not currently part of the MIPS program, but we anticipate being added to that program in 2019. A permanent fix is critical to effectively bringing therapy providers into value-based programs.

In closing, the therapy community stands ready to work with this committee to finally, after 20 years of extensions and moratoriums, repeal the therapy cap and find a permanent fix. Thank you for your time.

[The prepared statement of Dr. Moore follows:]

******** INSERT 1-6 ********

Mr. Burgess. The chair thanks the gentleman for his testimony.

Ms. Sanders, you are recognized for 5 minutes for your opening statement, please.

STATEMENT OF STACY SANDERS

Ms. Sanders. Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health, thank you for the invitation to testify. We applaud the committee for identifying bipartisan opportunities to improve Medicare.

The Medicare Rights Center is a national nonprofit consumer service organization that works to ensure affordable access to healthcare for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Since 1989, we have been helping people with Medicare understand their rights, navigate their benefits, and secure the quality healthcare they deserve.

Medicare Rights answers nearly 20,000 questions on its national helpline every year, and nearly 3 million Americans turn to our online tool Medicare Interactive. This free Medicare encyclopedia explains basic Medicare concepts and rules written to a fifth grade reading level. We regularly work with congressional offices as well who call us for assistance on constituent casework, and we welcome the opportunity to serve as a resource to the committee and beneficiaries nationwide.

My testimony focuses on our support for the Medicare Civil and Criminal Penalties Update Act of 2017, H.R. 3245. Fraud not only harms the Medicare program and the American taxpayer, but can have a very real impact on the lives of individual beneficiaries. In order to deter fraud and abuse, this bill would increase the civil monetary penalties, fines, and sentences allowable for specific types of Medicare fraud, such as the submission of false claims and the acceptance of financial inducements.

Let me expand on why Medicare fraud is deeply problematic. For people with Medicare, fraud and abuse can lead to exploitation in the form of increased costs, including overcharging for services or even paying for care that was never delivered. Seniors and people with disabilities may also be harmed if they receive unnecessary services or if needed care is withheld. Fraud and abuse also lead to increased and inappropriate spending of taxpayer dollars.

It is critically important that Congress prioritize policies to prevent and deter fraud and abuse. Existing oversight and enforcement initiatives have proven successful. Over the last 3 years, the Office of Inspector General and its partners recovered more than $6.10 for every dollar dedicated to healthcare fraud investigations. Of course, these or any enhanced recovery efforts must be implemented carefully so as not to inadvertently curb access to care should providers come to fear retribution for minor billing errors or honest mistakes.

A continued and enhanced commitment to fraud prevention and recovery can help ensure that people with Medicare are not overbilled

or otherwise harmed and that taxpayer dollars are spent responsibly.

Many of the administrative sanctions increased by this bill were established in 1981, and last revised in 1996, leading us to believe that these penalties are due for an update. And in 2011, the Office of Inspector General cautioned Congress that perpetrators of fraud may regard existing penalties as nothing more than the cost of doing business.

RPTR GENEUS

EDTR HUMKE

[11:02 a.m.]

Ms. Sanders. It is important to remember that there is a beneficiary-facing component to preventing Medicare fraud and mitigating the harms of abuse.

The federally funded State health insurance assistance programs, known as the SCHIAPs, and senior Medicare patrols work together in every State and U.S. territory to educate people with Medicare about how to protect themselves from fraud, to help them navigate cost-sharing challenges and billing errors, and to assist people with reporting suspected fraud and abuse.

We urge Congress to support these essential programs and secure their funding. Further, when fraud is uncovered, it is legislation like that introduced by Congressman Bilirakis and Congresswoman Castor, H.R. 3245, that is needed to ensure that those defrauding Medicare are appropriately penalized.

We look forward to working with the committee on this legislation and other bipartisan policies to improve the day-to-day experiences of people with Medicare and to strengthen the program now and into the future. Thank you.

[The prepared statement of Ms. Sanders follows:]

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

Mr. Burgess. The chair thanks the gentlelady. The chair notes that a vote has been called on the floor. We are going to hear from Dr. De Jonge, and then we will recess for the final three witnesses and then be back for witness questions.

Dr. De Jonge, you are recognized for 5 minutes, please.

STATEMENT OF DR. K. ERIC DE JONGE

Dr. De Jonge. Good morning. I am a geriatrician.

Mr. Long. Microphone.

Dr. De Jonge. Thank you. I am a geriatrician here in D.C., and I have been making house calls for 25 years. My team and I recently had the privileged of making house calls to a 113-year-old woman, who is one of the oldest people in the United States. Home-based primary care, supported by the Independence at Home Medicare program, allowed her to remain at home until the final day of her life.

Thank you, Chairman Burgess, and Ranking Member Green, and the members of the committee for inviting me to talk about the Independence at Home. On behalf of the American Academy of Home Care Medicine, we offer full support for the 2-year extension of the IAH Medicare demo, which otherwise expires on September 30.

Thanks to Representatives Burgess and Dingell, and also Representatives Roskam and Thompson for introducing the bill.

Today, I am going to do three things. I am going to discuss why home-based primary care and the IAH model works, review the IAH demo

results, and highlight the value of the 2-year extension.

First, why does the IAH model work? For seriously ill elders and their families, it supports 24/7 mobile, medical, and social services in the home until the last day of life. That allows life with dignity and skilled care in the home throughout the lifespan.

One of my patients is a Mrs. B. She was a 72-year-old woman, who presented for care in 2010 with liver and heart failure. In the last 2 years before that, she had been in the hospital for admissions 10 times. In the next 5 years, she received over 200 medical and social work house calls, hundreds of phone calls to family caregivers, mobile x-rays, IV treatment, medication delivery, blood tests in the home, and a lifesaving procedure for a GI bleed in the ICU at the hospital. In those 5 years, she had a total in 5 years of three admissions to the hospital and spent over 99 percent of her days at home.

Second, it works for providers and health systems. House calls build trust. It leads to more accurate diagnosis and better treatment that the patient and family want, better outcomes for patients and families, which is really satisfying for providers. Health systems get to serve highest cost populations in a preferred and lower cost setting, and they actually get paid for better results.

Our IAH consortium in mid-Atlantic with Penn, Virginia Commonwealth, and MedStar Health have received shared savings payments that have allowed us to grow our programs.

The VA is a national leader in home-based primary care and has also proven the high ratings of patient satisfaction and total cost

reduction over 10 percent per year in their 40-year home-based primary care program. Providers in many other States are ready to participate in the IAH model.

Finally, from Medicare, the IAH model has three big results. One, it provides better service to most the frail and sick elders in our communities and their families. It has a wonderful side effect of substantial total cost savings, because you are caring for people in their home and not calling 911 and ending up in the high-cost setting.

And third, practices are held accountable. They have six major quality metrics they have to meet. They have incentives to actually reduce total cost. So you have to create and be innovative and figure out what can I do in the home setting that will be better care but also keep them at home, and then they receive shared savings payments if they are successful.

There is also an accountable self-culling measure, where you remain in the program only if you meet the quality metrics and you show some -- you produce savings.

Some of the results of IAH over the last 5 years, we have served 11,000 patients and families nationwide so far; we serve patients who have serious chronic illnesses, at least two; they are physically disabled, and they have been in the hospital the past year and have had skilled home health or rehab, so they have high cost there proven.

In the year one of the IAH program, 9 of 17 sites exceeded 5 percent in savings and received payments back for an average of $3,000 per patient per year in savings. And in year two, 7 of 15 cites received

that 5 percent savings and received on average of 1,000 per patient. The total savings for IAH was $32 million in 2 years, about 50 percent of which was paid to providers to support the programs.

So the American Academy of Home Care Medicine supports the IAH extension for three major reasons; it will support the 15 current sites that can maintain the highest level of care and continue to save Medicare money; it will send a message to patients and providers all around the U.S. that this model is a success and can go to rural, urban, and suburban areas; and it will be a chance to apply lessons learned from the 5 years of the demo in the next 2 years.

So over 100 years ago when my patient was born, house calls were pretty routine. We can go back to that future and help keep Medicare solvent, and H.R. 3263 keeps us on that path. So I thank you for your attention, and I am glad to take questions.

[The prepared statement of Mr. De Jonge follows:]

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

Mr. Burgess. The chair thanks the gentleman.

Just prior to recessing, if the gentleman from Oklahoma would be interested in introducing his staffer that he had at the dais with him.

Mr. Mullin. I have the distinct privilege of having my son, Andrew, who is actually closed out a committee before. Andrew is up here for his birthday. It is his 12th birthday. And I always appreciate the committee for indulging me and allowing me to bring my kids with me.

As lawmakers, we are always away from our families. I have five kids, and the way that the committee supports us with having our kids with us, I really appreciate it. It means the world to all of us that are on the committee.

Thank you, chairman.

Mr. Burgess. Yes, sir. The Education and Workforce Committee would ensure that he was being paid by child care --

The committee is -- we have votes on the floor. I think it is a series of four or five votes, and I cannot give you the exact timeframe, but the committee is going to stand in recess subject to the call of the chair immediately after the last vote on the floor.

We stand in recess. We will hear from our last three witnesses immediately upon our return.

[Recess.]

[12:06 p.m.]

Mr. Burgess. The subcommittee will come back to order. As we recessed for the votes, we were about to take testimony from Mr. Morrison.

Mr. Morrison, you are recognized for 5 minutes for summary of your opening statements, please.

STATEMENT OF ALAN E. MORRISON

Mr. Morrison. Good afternoon, Chairman Burgess, Ranking Member Green, and members. I am here on behalf of the national association for the support of long-term care, and the association of providers of services to the patients of the post acute care sector, including clinical laboratories serving nursing home and homebound beneficiaries.

The bundled payment proposal in front of this committee would modernize very old and complex payment rules for laboratory services provided to nursing home and homebound beneficiaries. It will combine the three fees now paid, one for laboratory tests, one for the collection of specimens, and one for travel to the patient's location to collect the specimens into a single bundled, per episode payment.

Personally, I have worked in healthcare for over 40 years. We rarely see an initiative that can create program savings, ensure beneficiary access, encourage service to rural beneficiaries, permit provider efficiency gains, as well as address program integrity issue.

This proposal does all five of these.

According to an analysis conducted by the Moran Group, it saves approximately $130 million over 10 years. It ensures beneficiary access during a period of other significant changes and how Medicare pays for laboratory services. It provides an add-on payment to ensure access for rural beneficiaries. It eliminates the ability of unscrupulous providers to overbill the Medicare program for the travel fee, and it allows the specialized providers of these important services to better manage their logistics costs without impacting the quality of care.

We believe the proposed payment model is both good healthcare and good fiscal policy.

Let me explain how these services are provided and why they are so important. A very small segment of laboratory providers serves these frail elderly beneficiaries. These companies provide very basic laboratory studies used by ordering physicians to diagnose and monitor a wide range of conditions such as diabetes, heart disease, pneumonia, influenza, and asthma. They are very low-cost, basic tests with an average Medicare fee under $30, some as low as $10. In fact, in 2017, the most frequently ordered test was $10.66.

It is important for these beneficiaries to have access to these services. It enables them to receive care in the lowest cost setting appropriate for their needs; it avoids the need to transport patients for services and the costs, risks, and inconvenience to such transports, and by having these services available around the clock,

we avoid unnecessary ER visits and hospital re-admissions, and the substantial associated costs.

To provide these services, specially trained laboratory staff travel to the patient's bedside to draw blood samples and collect other specimens. They then transport them to the laboratory to process them, and the laboratory reports the results to the patient's physicians, and this entire process typically takes only 3 to 6 hours.

Because these patients often suffer from multiple disease and disorders, there is a very high percentage of critical results. These are immediately reported to the patient's physician so the needed treatment can begin at once.

As I mentioned, this specialized segment of laboratory providers serves these beneficiaries. The national laboratory companies and almost all hospital laboratories re-emphasize serving nursing home and homebound patients several decades ago.

In fact, in 2015, the two largest national laboratory companies provided less than 4 percent of these services to these frail, elderly beneficiaries.

The Medicare payment model for these services has been unchanged for over 30 years. In fact, we think it is the oldest surviving Medicare payment methodology. It is very complex, which is three separate payment components, one of which requires costly manual recordkeeping to log odometer mileage for each trip to each patient's location in order to ensure accurate and compliant billing.

This current payment model is also prone to program integrity

abuses by unscrupulous providers who gain the billing for the travel allowance payment component.

We believe that the proposal in front of the committee is a simply a better way to do this. It would bundle the three payment components into a single, per episode payment covering all included tests provided on a single calendar day to these beneficiaries regardless of the number of tests or number of trips.

The bundled payment would apply to the 100 highest volume tests, which represent 98 percent of the tests ordered and which have remained virtually unchanged over the past 6 years. Payment would be limited to one episode per calendar day.

Further, the proposed payment model includes a rural add-on to ensure access by rural beneficiaries. The budget savings would come from the Secretary setting payment amounts, such as the total payments on this bundled payment model. In 2017, equal 97.5 percent of the amount that would have been otherwise payable for the same top 100 tests, the specimen collection fee, and the travel allowance under current law.

We believe that with this proposal, we can get budget savings as well as good health policy and ensure beneficiary access to this population.

We hope that you share our enthusiasm of this initiative and the benefits it can bring to the program and its beneficiaries, and we thank you for your time and support.

[The prepared statement of Mr. Morrison follows:]

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

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

Dr. Kappor, you are recognized for 5 minutes, please, to summarize your opening statement.

STATEMENT OF DEEPAK A. KAPOOR

Dr. Kapoor. Chairman Burgess, and Ranking Member Green, thank you for inviting me to speak in support of H.R. 2557, the Prostate Cancer Misdiagnosis Elimination Act sponsored by Representatives Bucshon and Rush.

My name is Deepak Kappor, and I am a practicing neurologist specializing in the care of neurologic malignancies, including prostate cancer. I am also chairman and chief executive officer of Integrated Medical Professionals, the largest independent neurology group practice in the country, as well as clinical associate professor of urology at the Icahn School of Medicine at Mount Sinai Hospital.

Issues related to prostate cancer are of particular concern to physicians in my group. One out of every 80 men nationwide diagnosed and treated with prostate cancer is managed by one of my doctors. About one in seven men diagnosed with prostate cancer will be diagnosed with prostate cancer during their lifetime. This diagnosis is usually established by a test called needle biopsy of the prostate. We rely on the result of this biopsy to counsel our patients on what treatment options are available to them. The modern promise of precision

medicine and targeted therapy requires complete and total diagnostic accuracy in this test. However, despite best laboratory practices, the clinical literature has recently revealed a troubling persistence of prostrate biopsy complications, where a relatively high number of specimens have been switched or contaminated with tissue from another patient. These are known collectively as specimen provenance errors.

The reason for these errors is that the workflow for prostrate biopsy is extremely complex. The chart before you shows 10 different places within the diagnostic testing cycle where a patient sample can be transposed or contaminated by another patient's tissue. These errors can result in the patient getting the wrong diagnosis and, tragically, inappropriate or unnecessary treatment.

The literature shows these errors are frighteningly common. A 2015 study documented that over 2-1/2 percent of biopsy patients are subject to specimen complications. Perhaps even more troubling, the study concluded that at least 1.28 percent of patients newly diagnosed with prostate cancer actually did not have cancer at all.

As noted in the recent New York Times article, these medical errors have traumatic consequences on patients. Patients inaccurately told they have prostate cancer are subject to expensive invasive treatments such as surgery and radiation therapy. Patients, on the other hand, who were inaccurately told they do not have cancer, may miss the narrow treatment window, because the cancer is not diagnosed in a timely fashion with potentially fatal consequences.

There is a simple way to eliminate these errors entirely. DNA

fingerprinting with a DNA specimen provenance assignment test, which definitively rules out switching contamination errors that could lead to prostate cancer misdiagnosis. This process involves obtaining a sample of DNA by a simple noninvasive swab of the patient's cheek and comparing that reference test to the DNA found within specimens found to have prostate cancer.

In this fashion, all 10 points of potential errors in the diagnostic testing cycle are completely bypassed, and the provenance of the specimen is 100 percent verified.

To improve diagnostic accuracy and eliminate medical mistakes, our practice changed our treatment protocol to require a DPSA test to diagnose the provenance, which is the abbreviation for the provenance test, for all positive biopsies to ensure the right patient receives the right treatment, or where it is appropriate, does not receive treatment at all.

Importantly, this service is performed by an outside laboratory and not billed by my practice. There is no financial incentive for our physicians to order this test.

Not only does this test improve patient care, but elimination of diagnostic errors would lead to savings to the Medicare program.

According to an April 26 study by Millimen potential savings to the program from eliminating medical errors will be at least $539 million over 10 years. DPSA testing is widely used today. More than 60,000 prostate cancers per year receive the test and is offered by many labs.

In 2013, Medicare acknowledged that DPSA testing is very useful as a tool for avoiding error and misidentification of a patient with cancer. Despite this acknowledgement, Medicare asserts that it does not have the authority to pay for DPSA testing, because it does not explicitly diagnose or treat disease. This debatable interpretation of the Medicare statute is wasteful of Medicare resources and harmful to patients.

Congress can solve this problem by enacting H.R. 2577, the Prostate Cancer Misdiagnosis Elimination Act, which would require Medicare coverage for DPSA test for positive biopsies. The bill has the full support of the entire prostate cancer provider community, including the American Neurological Association, large urology group practice association, the men's health network, the Prostate Health Education Network, the Vietnam Veterans of America, and ZERO, The End of Prostate Cancer, to name but a few. I urge Congress to seize the opportunity to eliminate thousands of preventable medical errors, improve the healthcare of American men, and reduce the costs of the Medicare program by enacting this bill.

I thank you, again, for your time and attention.

[The prepared statement of Dr. Kapoor follows:]

******** INSERT 2A-2 ********

Mr. Burgess. Thank you, Dr. Kapoor.

Mr. Earle, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF CLETIS EARLE

Mr. Earle. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. My name is Cletis Earle, and I am the chief information officer at Kaleida Health and the chairman-elect of the College of Healthcare Information Management Executives, or CHIME, board of trustees.

It is an honor to be here today and to testify on behalf of CHIME concerning the Meaningful Use Program and to offer our support for H.R. 3120, a bill to reduce the need for Meaningful Use Program hardship exemptions.

In addition to serving as the chair-elect of the CHIME board of trustees, I am the CIO of Kaleida Health. Kaleida Health is the largest healthcare provider and the largest private employer in western New York State with more than 1 million patient visits recorded annually across our hospitals and health systems, 82 clinics and healthcare centers. Kaleida Health's economic impact on western New York exceeds $2.7 billion annually.

For those of you not familiar, CHIME is an executive organization serving nearly 2,400 chief information officers, or CIOs, and other senior health information technology leaders at hospitals, health

systems, and clinics across the Nation.

CHIME members represent some of the earliest and most prolific doctors of electronic health records, or EHRs, and other health IT resources for clinicians and patients.

Since the enactment of the HITECH Act in 2009, which established a Medicare and Medicaid electronic health record incentive program, also known as the Meaningful Use Program, the healthcare industry has made significant shifts in the way technology is used to treat and engage with patients.

Patients and providers have already benefited from the Nation's investments into EHRs in ways that would be -- not have been possible without the investment made through the HITECH act.

As an example, in another health system where I previously served as CIO, we were able to track hospital re-admissions that were related to asthma and correlate asthma-related hospital re-admissions to specific neighborhoods and specific properties. With that data, we worked with local officials to coordinate discussions with landlords to improve the conditions of specific properties within those neighborhoods.

These kind of population health activities would not have been possible if we did not have EHRs and access to data digitally.

Now, more than 8 years after passage of HITECH, we have the chance to make policy decisions apart from arbitrary deadlines and measures of her incentive program. The Meaningful Use Program has been plagued by the check the box, one-size-fits-all approach, that as one of my

CIO colleagues put it last week, put a Ferrari in every driveway but expect us to drive on dirt roads.

The her mandate for use of Meaningful Use Programs has made a great deal of functionality and promise and could have been even greater resourced in patient care; however, as we strive to meet CMS program deadlines, we aren't able to pursue workflow enhancements with our EHRs or other health IT tools that would actually improve outcomes.

Moreover, our her vendors, are so focussed on meeting this specification and certifications that they don't have the bandwidth to work with us on functionalities that our clinicians actually request.

Another colleague CIO in a rural area explained that to get ready for stage three, which is slated to be in 2018, they have to re-evaluate the use of a successful postoperative telehealth program as there aren't enough resources to service both programs.

The Meaningful Use Program was resounding success in terms of adoption as EHRs use a nearly ubiquitous approach across hospitals and provider offices; however, we are all familiar with the discontent these systems have caused providers. The measure and objectives have not reflected improved outcomes for patients' and clinicians' needs. As many as 256,000 Medicare physicians in one year have been subject to financial penalties for the failed attempts at meaningful use requirements while as many as 30,000 others have had to apply for hardship exemptions.

Unable to participate in a program, we have an opportunity to do

better and pursue common sense policies, including H.R. 3120, which will infuse necessary flexibility to make Meaningful Use Programs meaningful again.

As hospitals and providers continue to struggle to meet timelines and requirements of Meaningful Use Program, there will be -- become an increased reliance on hardship exemptions. We commend our approach to take -- taken in H.R. 3120, rather than propose the elimination of Meaningful Use Programs or insist the requirements remain stagnant in perpetuity, it leads it to the discretion of the Secretary to modify the requirements over time as deemed necessary in conjunction with the industry.

Meeting thousands of pages of requirements places unreasonable demands on limited resources and finances. The ability to shift away from continual turn would be a welcome development for provider community to bring much needed stability.

There is no question committee's interest in the topic is timely, and efforts to usher in an era of digital care is a must. On behalf of CHIME and my colleagues and the healthcare CIOs, I sincerely thank the committee for allowing me to speak on the opportunities to improve Meaningful Use Program and reiterate our support for H.R. 3120. I look forward to answering your questions.

[The prepared statement of Mr. Earle follows:]

******** INSERT 2A-3 ********

Mr. Burgess. And the chair thanks the gentleman.

Thank you to all of our witnesses for providing the information this morning. We are now going to move into the question-and-answer portion of the hearing.

And I am going to yield my time to Mr. Griffith of Virginia to begin the questioning, 5 minutes.

Mr. Griffith. Thank you very much, Mr. Chairman. I do appreciate that.

Dr. Kissela, you mentioned that estimates suggest approximately 50 -- excuse me -- approximately 522,000 Medicare beneficiaries would be eligible for a telestroke consultation including those in rural areas who currently do not meet the definition of rural for Medicare payment of telestroke services.

Can you elaborate on how patients in many rural communities are still facing a barrier to consultation and treatment despite the current law?

Dr. Kissela. Sure. So the definition of rural under Medicare is very arbitrary, and there certainly, in our region, for example, in our 27 hospitals, we have outlying hospitals that really have no access to stroke neurology expertise on a moment's notice for an acute stroke emergent situation and would not meet the definition.

And so being able to apply this equally will solve that problem for our outlying hospitals as well as helping the speed of treatment at our urban and suburban areas where we really need to move fast as well where most of the strokes are.

Mr. Griffith. I believe I saw that the target times to try to get that -- get the treatment within 60 minutes. Is that correct?

Dr. Kissela. That is correct. From the minute they reach medical attention, the door to needle, as we say, to the first time when the drug, TPR, is given, the national goal is 60 minutes.

Mr. Griffith. Now, I think we all know the long-term consequences for patients who don't properly receive an evaluation and treatment for stroke, it can be devastating to the quality of life, if not fatal.

That being said, one of the fights we often have up here is about money, and this bill will probably score in the way CBO does things is costing money. But my gut is that these patients will receive so many services that are going to be covered by Medicare if they don't get TPA in a timely fashion that it is going to cost us a lot more.

So could you just confirm that feeling and tell me what services the patients often have to seek if they suffer from an ischemic stroke and do not receive the TPA within the window?

Dr. Kissela. Absolutely. So to your point about quality of life. It is a devastating disease. People have rated the living with stroke to some often worse than death, although it is a fatal disease as well. So it is a terrible burden on families as well. Families, of course, have to take time to care for people who are disabled by stroke.

But the services specifically that a stroke survivor will need would include all forms of therapy services to work on trying to recover

their deficit. The way to bring recovery after a stroke is for the good brain to try to take over the function that was lost, but that is a very difficult process. It is often unsuccessful. And for the largest of strokes, institutional care is necessary.

So they may live for years in a skilled nursing facility, there racks up a tremendous expense. And so even if the estimate from the American Heart and Stroke Association that I mentioned is too high, I am completely convinced that the ability to give TPA and a lifesaving stroke therapies to other patients, more patients, in a timely fashion will no question save money for the healthcare system at large.

Mr. Griffith. Well, you know, I am not a medical person. I am a country lawyer, but I had a case one time where I had to go to an institution where a relatively young man had had a significant stroke, and we had to prepare documents for him with him blinking. His mind was -- his ability to reason was fine, but he couldn't move, and he couldn't talk. And so he just laid there and watched. It was heartbreaking for the family, but I prepared the legal documents and made sure that they had access to everything they needed to have access to legally to take care of him.

But there is a case where I don't know how many -- probably millions of dollars, because there was absolutely nothing else physically wrong with him, but he was expected to live for quite some time.

And that is -- while it may not be commonplace, it is not rare. Would you agree with that assessment?

Dr. Kissela. I absolutely agree. It is heartbreaking every day when we have opportunities to treat patients effectively, and we are not capturing that opportunity.

Mr. Griffith. And this is not something that is new off the shelf. This TPA has been around for how long? 15, 20 years?

Dr. Kissela. It was approved by the FDA in 1996.

Mr. Griffith. 1997, so 20 years. It is high time that we get it to more people quicker. Wouldn't you agree?

Dr. Kissela. Absolutely. Thank you, sir, for your support.

Mr. Griffith. I appreciate it very much.

Mr. Chairman, I yield back, and I appreciate your patience.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman. I appreciate your recognizing me.

And I want to thank all of the witnesses. This is really quite a panel and it spans so many areas of care and improving care in our healthcare system.

I have to leave. I came back because I wanted to thank you, and I just wanted to make a comment about one area, and then I have to leave, because I have got to get my flight to get back to California.

So, again, my thanks for the testimony and to all of the members that have worked together to produce the bills that are being reviewed

today.

I want to make some comments on -- and I am going to sound look a skunk at the garden party, but I want to make some points about the Independent Payment Advisory Board, the IPAB. I don't know how many members have read the CRS report on this. The most recent one was in March of this year, March 17th, I believe. If you haven't read it, I would suggest that you do.

I understand the resistance to this. Interest always looks at things and say, you know what, our ox may be gored.

I understand that, and some of the things that were said in opening comments that Congress is the one that should be in charge, I agree with that. But I don't think that we should rush to eliminate this. And let me tell you why.

There isn't anything that is being done about right now. There is cost shifting going on with bills relative to our healthcare system, but there isn't anything to address the costs and how we are going to sustain the costs in the system. For those that say Congress shouldn't give up and the -- I don't know whatnot, all of that, let me offer a very good example.

Congress recognized years ago that collectively it didn't have the political will, because it was really tough to do, to close military bases. And the BRAC commission was established. And you know what, I think it worked well.

Now, there are many sensitivities when it comes to the decisions relative to Medicare. I think that there still should be a commission

that is put together that advises the Congress. Congress is not going to do this on its own. And just look at all of the interests, the beautiful, important interests, that are represented here today. Each one has a great case. Nobody talked about how we are going to pay for a darn thing. And that is not your responsibility to do, but it is ours.

So I think that there is a case to be made for a mechanism that would really review these things with the kind of representation that is deserved and should be a part of a commission with the seats representing all the various stakeholders, because those voices are really important, but recognizing that the Congress, yes, should be the one that accepts or rejects the advice.

So I am still driving but with an emergency brake on. I think there is a rush to judgment here about the value of having an outside group when the triggers come up that would review all of this and, overall that together, between an advisory commission that would make recommendations to Congress, that we make sure that what we are spending and investing in is actually sustainable. And I don't think that we are taking that into consideration.

Again, all of these healthcare bills that are out there now being debated, the ones that passed, the ones that didn't, the ones that are still in the hopper, there is cost shifting in it, but there is no mechanism in any of them about how we are going to sustain growth and be able to afford the growth that is in the program.

So I am really very hesitant about the bill. I think it needs

to be reworked and amended. I may be the only one in the entire committee that views it this way, but there has been, I think, a very good example, BRAC. And BRAC has worked. BRAC has worked. And I am not even suggesting that this be set up like BRAC, but members are making it sound like, you know, all hell is going to break loose; the sky's going to cave in, and we just have to blow this thing apart and not have any mechanisms whatsoever.

I think that is a march to folly. We have a responsibility here to not only know what need -- improvements need to be made, by overall where the costs are going. And we do that because Medicare is invaluable. You can't place a price tag on it. But whatever the price tags are, we are going to have to come up with the money for it.

So thank you, Mr. Chairman, and I hope that -- I am sorry that there aren't more members here to hear what I said, but maybe they wouldn't be agreeing with me anyway, but I stayed to thank the witnesses and to put my statement into the record, because I think it is something that we really need to think through.

Thank you, and I yield back. And have a great weekend, everyone.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions, please.

Mr. Guthrie. Thank you very much.

Dr. Kissela, Morgan Griffith asked a lot of what I was going to ask. But I want to ask this. He says he is a country lawyer. I am

not a doctor nor a country lawyer, I am just country. But I have a lot of rural areas in my district, and so it is something that is important.

I was actually at a rotary club outside of Lexington, and they were talking -- and a person came and presented from the neurology center on strokes, and said get -- these are the symptoms, get him to the hospital as soon as possible, the stuff they were talking about and how -- and I was thinking how we deal with this with telemedicine.

Because first something, why don't we just give everybody the medicine and then one wouldn't be in an ambulance. And the reason is, they explain this, that two types of strokes -- well, there is more. But as a country person would say, one is a blood clot and one is bleeding on the brain. And you give them -- based on what they said, if you give medicine for bleeding on brain -- for a blood clot and there is bleeding on the brain, then you have more damage.

So how do you actually assess somebody via telemedicine? How does that work? We can get that quick diagnosis say, this is what you need to do as opposed to the other?

Dr. Kissela. Absolutely.

So, first of all, I am just a plumber. So I would -- so when we log into telemedicine, we have the option to -- we are visualizing the patient; we are talking to them, and so that history and physical is an important part of any medical encounter. It is so much better to be able to do that yourself rather than rely on somebody's else account of what happened and to hear about what the exam looked like, I can

see it with eye eyes.

And we have a very standardized way of evaluating the patient clinically in a very rapid fashion that is helpful. But then all the telemedicine systems, these are why the systems are kind of costly and expensive to implement. They have to be secure. They have to be 100 percent reliable, because this is a life-and-death decision where every second counts.

But then they also have -- it is not just the capability to see the patient but also to see the radiologic film. So we do a head CT scan, and that tells us if there is a bleeding stroke or a not bleeding stroke.

Mr. Guthrie. Well, thank you for that.

And, Dr. Kapoor, on the biopsies for prostate, often, in your best estimate, do you think the errors in the needle occur, errors in the needle biopsy occur? How often does that happen?

Dr. Kapoor. Well, it is important to understand that the error is not precisely the biopsies. It is in the analysis of the biopsy and the diagnostic testing cycle. So the biopsy --

Mr. Guthrie. Oh, yes. I said that wrong.

Dr. Kapoor. But the data shows that it occurs in about 2-1/2 percent of cases overall. And unfortunately, nearly 1.3 percent of the time the patient doesn't have cancer. Importantly, the literature --

Mr. Guthrie. This is always false positive -- I mean always false negative or is it a false positive?

Dr. Kapoor. It could be either way.

Mr. Guthrie. Right. So some people don't get the treatment they need?

Dr. Kapoor. It depends on the type of error. Because sometimes tissue can be contaminated from another patient, other times the tissue can be completely switched so that patient A is being diagnosed, given the diagnosis of patient B and vice versa. So the person that is being read as negative actually has cancer, and there is somebody else that is being read as positive that doesn't.

And this does occur at other malignancies as well. You know, there was a notable case on Long Island where a woman had -- unfortunately, had a bilateral mastectomy because of a switching error. It is just because with prostate biopsies, we do 12 to 20 core samples per patient as opposed to one or two that the errors are magnified, because there is just so much more tissue that is being handled in a prostrate biopsy.

Mr. Guthrie. Thank you very much.

And Dr. Moore, can you detail to the committee why simply extending the processes around the therapy caps for another year or two is not the best practice for beneficiaries, providers, and as matters of Medicare fiscal health?

Mr. Moore. Yes. Thanks, Congressman. I think the best rationale is it is time to make that permanent change. We have extended this out at a cost. We have extended this out out at uncertainty to the field and to the therapy providers, and we now have changes that

were made as part of MACRA that the chairman recommended -- or talked about in his opening statement to move to targeted medical review. It seems to be working.

And so our analysis shows that as we move toward that change that was made in MACRA, that we are striking that critical balance of ensuring access to care but also maintaining the integrity of the program.

And so we think that extending the exception process only delays and costs more over time, and that we have the data and the policy solutions available for a permanent fix at this time.

Mr. Guthrie. Okay. Thank you.

And, Dr. Richards, I am running out of time. This committee has worked with Senate Finance, and House Ways and Means on a bipartisan basis since the beginning of last year on the issue of home infusion. While not everyone got everything they wanted, do you believe the policy with further technical changes as reported out of committee last week should advance to the House floor?

Mr. Richards. Thank you for that question. Yes, I do. I think it will give us an opportunity to see this transitional payment plan come through with all support of technical changes.

Mr. Guthrie. Okay. Thank you. And I will yield back.

Mr. Burgess. The gentleman yields back.

Mr. Guthrie. I have 13 seconds. I have two requests for unanimous consent to enter it into the record.

Mr. Burgess. Start the clock back.

Mr. Guthrie. National Association for Supportive of Long-Term Care, and then American Speech-Language-Hearing Association.

Mr. Burgess. Without objection, it will be made part of the record.

[The information follows:]

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

Mr. Burgess. The chair recognizes the gentleman from -- the gentleman from Pennsylvania, Mr. Murphy, 5 minutes.

Mr. Murphy. Thank you, Mr. Chairman. This is fascinating to me. I like to use the analogy that if you buy a car off the lot, maybe about 25-, $30,000, if you buy the same car from the parts department, it may be at least $150,000. That is the difference between fee for service and a disorganized system versus one that is very coordinated.

Along these lines, Dr. Richards, when you write about disease state management of highly complex chronic illnesses, you talk about the care coordination, the drug interaction, monitoring, et cetera, et cetera. I might add to that as well, on the issues of diabetes, which has massive amounts of complications, including behavioral issues, depression, anxiety, panic. And we know that a person with a chronic illness doubles the risk for psychological problems such as depression, and untreated depression doubles the cost, because oftentimes, it means the person is not getting better.

And Dr. De Jonge, you talked about this too in terms of working at home. That is the primary care person looking at everything. And, Ms. Sanders, when it comes to Medicare and looking at patients' right, people are denying just based upon a number versus what does this patient need to make them better, especially in the communication area, you end up with a lot of complications. A noncommunicative person, perhaps because of a stroke, who has all their faculties involved increase these problems.

So I want to know from each of your points of view real quickly,

do these bills adequately address, do we need to do more when it comes to care management, disease management, and two, do you think it costs more or less to do that? Let's start with talking about diabetes. Give you about 25 seconds, each of you. Go.

Ms. Aprigliano. I think that for anybody who has a chronic disease, the importance is to have a successful management plan and these individualized. So looking at all of the complex issues, it is crucial. When I hear about home-based care, that is an essential way for, especially individuals with complex diseases like diabetes, to have access to multiple ways to treat.

Mr. Murphy. So does Medicare currently provide a funding mechanism for the medical practice people for other people to coordinate that care or does this happen because people are trying to do themselves? If we need more, let me know.

Ms. Aprigliano. So for diabetes, we are self-managed. We spend very little time with medical professionals. Diabetes is 24/7. And so we are responsible for making sure that we stay healthy. And the onus is on us to have the equipment, to have the services so that we can stay healthy to this prevent the constant complications we have.

Mr. Murphy. Dr. Richards.

I would love to ask this of all of you, but I only have 2 minutes left, so go ahead.

Mr. Richards. Most definitely there is a cost savings. And the fact that if the patients aren't going to be able to do this in the home, and these are long-term threatening illnesses, they have to seek

a different site of care, which typically is going to be a higher cost. I mean, that is the bottom line. I mean, home is proven to be cost effective, safe, and it is really where patients want to be.

Mr. Murphy. Ms. Sanders, does Medicare adequately pay for making sure that these things are coordinated, such as, for example, if a person does need a communication device, do we really pay to make sure that there is mechanisms to determine if that patient needs it, and it is improving or not improving care? Do we have a mechanism now, or do we need to fix that?

Ms. Sanders. I think that, you know, we -- Medicare rights center, we certainly know from the direct experience on our help line that people struggle to coordinate and manage their care on their own. Many of our callers are low income. They have multiple chronic conditions, and they need help managing the variety of services, devices, and otherwise, you know, prescription drugs that they need.

So we have been very supportive of value-based payment models and the ways in which Medicare Advantage plans are coordinating care. And I think that Congress should commitment to those efforts in all parts of Medicare.

Mr. Murphy. Dr. De Jonge, for about 45 seconds. Because you put that measure, quoting about 5 percent of people consume about 50 percent of the costs. Do we do enough to really pay for people to manage those complex cases?

Dr. De Jonge. Yeah. Right now, there is a lot of fragmented billing for these different patients. And I think if you think about

having a team that quarterbacks the care of that whole patient their whole life until they die and pay them for results and not for each little thing you do to them makes a lot more sense.

And Independence at Home, I mention the VA program have shown that if you have a team that is mobile, that does all the care in the home environment, most of the care in the home environment, you can actually have more satisfied patients and families, and you can reduce Medicare costs substantially if you do coordinate it that way.

Mr. Murphy. No. I have seen some studies that even say as much as the 40 percent savings on some of these. Because every time someone shows up in an emergency room, that is preventable and preventable hospitalizations, and it goes on and on.

So I might see -- as we look at other areas to reform the health system, I think this is critical if we look at even providing a block grant to a State. I think that when we talk about such things as, you know, high-risk pools -- I don't like that term at all. I would much rather say for those who are in the 5 to 10 percent that consume the cost, the overutilizers, we ought to be thinking of a payment system that really pays for coordinated care to help them.

So I appreciate you all highlighting that. I know you -- others had it too. But this is very, very important. Thank you very much, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yield back.

The chair recognizes the gentleman from Florida, 5 minutes for

questions, please.

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

And I agree with Mrs. Blackburn. I think she called you all a football team. But, anyway, you all are all stars. There is no question. We have an all-star cast here this afternoon, this morning when we started.

Thank you, Mr. Chairman, for putting it together.

I have a question for Ms. Sanders. I appreciate your testimony this morning and the work you do with the Medicare beneficiaries. Thanks so very much. And I look forward to working with you in the future too on behalf of my constituents.

Medicare fraud is not a victimless crime. You reference in your testimony the impact that the Medicare fraud has on beneficiaries. Could you give us some additional detail or details on that and perhaps a case example. If you could elaborate. I know you addressed it to a certain extent this morning, but you only had the 5 minutes. So if you want to elaborate on that, I would appreciate it.

Ms. Sanders. Sure. Yes. Thank you for the question.

So many callers to the Medicare center are calling because they either can't afford a bill, or they are concerned that they have been overcharged for some type of service. So at the Medicare aid center, our counselors then do some investigation into what is going on with that case.

And in one example, in speaking with both the beneficiary and the healthcare provider, we saw that the provider had, in fact, charged

the beneficiary over the Medicare approved amount, the allowed cost sharing. That is a case where we would refer that beneficiary to the senior Medicare patrol or to the Office of the Inspector General to see if this is a simple billing error, perhaps it was an honest mistake, or it may be a case of fraud.

So, again, you know, typically, these issues come up with respect to billing concerns. Those are the fourth most common call to the Medicare right help line, but it is not immediate to us whether or not there is fraud. We have to -- that investigate that, our partners do.

Mr. Bilirakis. I see. Does it make sense to have penalties that have not been updated in over 20 years?

Ms. Sanders. No, not from our perspective. We think that Congress should certainly update these penalties in order to ensure that we have appropriate prevention and we are deterring fraud.

Mr. Bilirakis. Very good.

I appreciate your support for -- for my bill and Representative Castor's bill.

You mentioned in your testimony some findings by the OIG and GAO regarding fraud and how individuals perpetrating fraud view the penalties as a cost of doing business. At the same time, you also mentioned concerns about enforcement actions to put beneficiary access to care at risk by potentially shutting down hospitals or other providers. Are you suggesting that there needs to be a balanced approach in the application of these enhanced penalties?

Ms. Sanders. Yes, absolutely. I think that balanced approach

is very important. We need to have strong penalties to deter and prevent fraud. But I think we have to recognize that the Medicare system is very complex, and there will be incorrect billing, and there will be honest mistakes. So we really need to, I think, lean on Office of the Inspector General and their partners to use their discretion appropriately so that they are, in fact, penalizing true fraud and not those providers who are, you know, doing their best but making mistakes along the way.

Mr. Bilirakis. And does the panel basically agree with that statement pretty much? Thank you.

Mr. Moore, can you detail the various program integrity measures your coalition has agreed to over the years?

Mr. Moore. Yes. Over of the years, due to the number of times the therapy cap has been addressed, there have been a number of measures that have gone into place to ensure the integrity of the program, and those include the exception process that is -- expect to expire, but what has worked really well has been the targeted medical review that was put in at MACRA. It has really allowed the agency to strike that balance to ensure access without applying broad-based utilization controls that might delay access or eliminate access. So that has probably been the most successful.

We also are seeing that transition to quality-based programs, whether we have one of our -- one of the extensions reporting on functional limits has been added to the benefits to understand what is going on in therapy and then, obviously, participating in the quality

programs that have come out of this committee and Congress.

Mr. Bilirakis. Very good. I appreciate that.

RPTR ZAMORA

EDTR SECKMAN

[12:51 p.m.]

Mr. Bilirakis. Very good. I appreciate that.

Thank you very much, Mr. Chairman. I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for questions, please.

Mr. Carter. Thank you, Mr. Chairman.

And thank all of you for being here. All of you represent areas that are extremely important in the healthcare system, and I can't tell you how much I appreciate that.

As a practicing pharmacist for over 30 years, I have interacted with just about every one of you, and I want you to know that it is a team approach. And all of you played an important role in that, so thank you for what you do.

I want to start with you, Ms. Grealey, if I could. As the president of the Healthcare Leadership Council, you have made it clear that you feel like we should be moving more towards a patient-centered Medicare system without the Independent Advisory Payment Board.

I know that IPAB was set up to save money and that the main way that they were going to be doing that was through cutting physicians' fees. What do you think that would have done to Medicare? What do

you think that will do to Medicare if we don't pass the legislation doing away with it?

Ms. Grealey. I think the number one effect will be to reduce access to care for Medicare beneficiaries. There are certain protections in this legislation that say you can't cut the benefit package for Medicare beneficiaries, you can't change their copays and deductibles, you can't change their eligibility.

But what it fails to recognize is cutting payments to providers will limit access to those providers for Medicare beneficiaries. So there is a very direct effect.

Mr. Carter. Absolutely. Thank you very much for that.

I want to move now to Ms. Aprigliano. Was that pretty good? I hope it was.

Ms. Aprigliano. As close as anybody ever gets.

Mr. Carter. Is that right? Good. Thank you. Thank you.

I found your -- I will be quite honest with you. I was not prepared to ask you questions when I first came in here, but I was here when you gave your opening remarks, and I found it to be very relevant particularly with community pharmacists, because I know the role that community pharmacists play with consultation for all areas, but particularly for diabetics.

And that is where it is so important. And I was very interested in what you had to say about the required mail order and how that had actually resulted in something that we didn't -- that we tried to push onto someone, but what happens is that they end up going back to their

community pharmacists. And why is that? Why do you think that is? I mean, just --

Ms. Aprigliano. So, while the National Mail-Order Program is fantastic in the sense that for individuals who are homebound or have difficulties getting to their pharmacy or their pharmacy is very far away, this is a great program. However, a lot of patients do need that extra support from a pharmacist. They are part of their healthcare team.

And so the other issue is, is that the majority of individuals, if they are given a meter that is not accurate, they will go to the pharmacist and say, can you tell me why this doesn't seem right, because my blood sugars before were this and now all of a sudden they are this?

So we are finding individuals going back to their pharmacy and talking with their pharmacist, because these meters that we have now shown through the study through the Diabetes Technology Society are not accurate. And so this does impact.

So it is important. National mail order is great for individuals who can use it, but we do need to have the ability to have the meters that are accurate and the ones that they are comfortable working with.

Mr. Carter. Great. Thank you for that, and I appreciate that.

You know, Mr. De Jonge, I was a consulting pharmacist in long-term care setting for many years. And one of the primary reasons that people were admitted to the nursing homes, if not the primary reason, was medication administration and having someone who could make sure that those patients were taking their medications.

I just wanted to get your input on how important of a role that is in the home setting.

Dr. De Jonge. Yeah, there is kind of a perfect storm in the really frail elders where they are more vulnerable and they take a lot more medications. So you need constant vigilance and the kind of home-based primary care approach, where you have NPs and docs and nurses, and we have pharmacists actually at our weekly team meetings who are reviewing the med list with us.

So, on a weekly, if not daily, basis, you need to be carefully monitoring the meds, their side effects, and their toxicities, and that prevents ER visits and unnecessary hospitalization.

Mr. Carter. So, in the end, it saves money?

Dr. De Jonge. I mean, I think the data both --

Mr. Carter. And keeps them from going into the nursing home many times?

Dr. De Jonge. You know, no one wants to -- not many people I talk to want to end up in a nursing home.

Mr. Carter. Sure.

Dr. De Jonge. So, if they can avoid the trip to the ER and the hospital, that is often the next step to the nursing home. It helps prevent that.

Mr. Carter. Well, running the risk of being accused, of being self-serving, I mention all this because it is important, because it is a team approach. And, certainly, all of you, as I said earlier, play an important role in that. Certainly, pharmacists play an

important role in that.

And I want to have a plug-in for my colleague, Representative Guthrie, who has a bill, H.R. 592, for Pharmacy and Medically Underserved Areas Enhancement Act. I hope that we will look at that, Mr. Chairman, because that is a very important bill.

Yes, it will cost some money initially, but right here, you see where it will save us a tremendous amount of money. Not only will it save money, but it will also increase the level of care that patients are getting, and that is the most important thing it does.

And I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from California. Just prior to recognizing the gentleman from California, for those who were concerned that I was ignoring Dr. Ruiz, he is actually not a member of the subcommittee. He is a member of the full committee. He is waived onto the subcommittee. Generally, the persons who waive onto the subcommittee go after all of the committee members have asked their questions. However, the chairman is generously going to allow Dr. Ruiz to go first. And you are recognized for 5 minutes.

Mr. Ruiz. He says that because there are a lot of my friends out here, see.

Thank you, Mr. Chairman, for holding this hearing. H.R. 849, the Protecting Seniors' Access to Medicare Act, which repeals the Independent Payment Advisory Board, or IPAB, is a terrific example of

both sides working together to make commonsense changes to help patients and to help seniors.

In this day and age, it is wonderful to see some bipartisan effort to come up with some pragmatic approaches and make some changes that will result in good outcomes.

I appreciate Dr. Roe's leadership on this issue. It has been an honor to work with him on this important legislation, which will help protect seniors' access to Medicare.

And there are basically two main reasons why we must repeal IPAB: First and foremost, cuts to Medicare should not be made by unelected appointees who are not accountable to the American people. Seniors will not have a voice on determining whether they agree with those cuts or don't agree with those cuts, nor should one person in the case, if they don't agree or there is not a board, the Secretary of Health and Human Services, regardless of party, whether they are Democratic or Republican, under the direction of any President, regardless of party, be the sole decisionmaker on this matter.

That is not how we make decisions in something so important. Because Medicare is just simply too important for our seniors, who already struggle to make ends meet, to be subjected to cuts in this way.

Furthermore, IPAB efforts to lower Medicare costs, although well intended, by cutting Medicare payments is misguided. We need to work on lowering overall costs, like the cost of medicine and the cost of healthcare, in order to strengthen Medicare through cost savings.

The IPAB approach to cut payments may jeopardize seniors' access to care. The American Medical Association shares this concern. In a statement released today they state that, quote: Arbitrary IPAB physician payment cuts may create Medicare access issues for beneficiaries. Specifically, physician reimbursements under Medicare could become so low that physicians have to stop accepting Medicare patients.

I ask unanimous consent to submit this statement for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Mr. Ruiz. We need to rein in our out-of-control healthcare cost, no doubt about it. This is the primary reason why premiums, health insurances are going up. Medicare is having to pay too much, like the cost of medicine, in order to strengthen the solvency of Medicare not make arbitrary cuts that will hurt our seniors. Again, this bill today is a good bipartisan effort to put seniors above partisanship and solutions above ideology.

Ms. Grealey, as we know, IPAB was not triggered this year. Can you clarify why we can't or why we shouldn't wait and repeal IPAB later?

Ms. Grealey. Well, Congressman -- and, again, thank you so much for cosponsoring H.R. 849, very important legislation -- we can't afford to wait. We have an opportunity right now, through the joint resolution that you have sponsored, to go ahead and just get rid of IPAB completely.

We could wait until later in the year and do the repeal bill, but either way, it needs to occur as soon as possible. Because if IPAB does trigger and that whole process goes into effect, there is a very short timeframe. One, the cuts have to be achieved within a 1-year time period. And the opportunity for Congress to head off those cuts is not much of an opportunity at all.

Mr. Ruiz. So let's talk about that. Let's say they make a decision. Cuts are being made. What are the chances of overriding it? Tell me about that process, and can Congress override recommendations that they don't like or the policies that they don't like?

Ms. Grealey. If Congress does not like the recommendations made by IPAB, they would then have to propose cuts equal in size to what IPAB was trying to reduce. And they would have a very short time period in which to do that.

Mr. Ruiz. In other words, they are set up to fail that endeavor because it is a short time and -- I was going to give a dig at my friend here, their side, but I won't in the sake of bipartisanship. Sometimes it takes a long time to fulfill promises that people make to try to --

Mr. Burgess. Would the gentleman yield?

Mr. Ruiz. Yes, sir.

Mr. Burgess. The chair reminds the gentleman that the Independent Payment Advisory Board was not supported by a single Republican in the 109th Congress.

Mr. Ruiz. Oh, that is not the promise I was thinking about, but never mind. We have a good relationship.

Many people think that because no one has been appointed to IPAB that there can be no cuts at all. Is that true?

Ms. Grealey. Absolutely not true. If there is no member of the board appointed, we don't have a board, that authority, legal requirement then goes to the Secretary of HHS. So, today, that would be Secretary Tom Price. It could also be a Democrat in the future. But, either way, the Secretary of HHS then has that legal responsibility to make those cuts.

Mr. Ruiz. Thank you.

And I just want to echo -- I know Dr. Burgess and I have had

multiple conversations about IPAB throughout the years. He is very supportive of this. And I urge the chairman and the Democratic leadership to expedite this process so that we can have a markup hearing as soon as possible. Let's pass some legislation that is a true bipartisan effort that will help seniors throughout the Nation.

Thank you. I yield back my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

I will recognize myself now for questions. And, Ms. Grealey, on the Independent Payment Advisory Board, since Dr. Ruiz brought it up -- I didn't bring my copy of the Affordable Care Act. Normally, I have it with me and I am able to hold it up. I used to have the section on the Independent Payment Advisory Board section memorized because it upset me so much. And when you look at the list of people who are board members on the Independent Payment Advisory Board, I mean, it outlines -- you have government officials. You have eggheads from think tanks. At the very last, a practitioner of medicine or osteopathy. One. But you must not earn outside income, so that means someone who is not in active practice. You have no practicing physician on the Independent Payment Advisory Board. And, yet, as you point out, Ms. Grealey, it would have an outsized effect on patients and providers.

So, Mr. Morrison, let me just ask you. You spent some time talking about bundle payments. I will admit, not a big fan. But some of the things that you talked about as you went through trying to bring

some sense into your world actually did make sense. So how did we end up with something that is as convoluted as what you describe?

Mr. Morrison. Beats me.

Mr. Burgess. The chair thanks the gentleman for his honest answer.

Mr. Morrison. It is about the most convoluted payment system in Medicare, and I think it is the oldest existing system in Medicare that has not been looked at for at least three decades. I wasn't in the industry then, so I bear no responsibility for it. But --

Mr. Burgess. Me either.

Mr. Morrison. -- we just think it is time to move forward. And in deference to the member from Pennsylvania, Medicare forces us to pay for -- forces us to bill for parts. We are happy to bill for an entire car.

Mr. Burgess. I got you.

Well, thank you, and thank you for your testimony today. It was -- again, I feel a little bit like Representative Carter. I hadn't prepared to ask you a question, but when you detailed the very -- how you have to circumnavigate the globe to get from point A to point B, it really was troubling.

Mr. Earle, thank you for being here. Thank you for the work you do on the efficiency and the efficacy of electronic health records. You know the legislation, 3120, that I have cosponsored with Representative Dingell from Michigan that removes the mandate to make universal -- I mean, make meaningful use standards increasingly more

stringent.

I am going to ask you a softball question. Do you support the policy?

Mr. Earle. Absolutely.

Mr. Burgess. Right answer. Good deal. So why is it important to allow providers to catch up?

Mr. Earle. We have been -- the ball has been moving significantly when it comes to electronic medical records and meaningful use. So this will give us the time to, if we are able to pause, it gives us the time to actually work at giving and delivering the right technology and solutions for our providers, in essence, for our patients and provide the right amount of care.

So pausing it out would allow us that opportunity to, again, drive our technology initiatives to, again, have a better result.

Mr. Burgess. And then is there a downside if we don't allow that pause?

Mr. Earle. No. I don't think there is a downside. You know, from our perspective, you talk about bundle payments and, you know, what we are doing with the 21st Century Cures Act.

That is a natural -- what we are seeing is the legislation out there, it is really allowing us to continue to push our efforts forward when it comes to interoperability and sharing information so that we can actually continue to do, you know -- improving the system and having better results without the stick, you know, as far as you have to make these changes, you know, every year or, you know, in a more routine

basis. So I don't see, and I don't think our organization sees, downside. There is just upside here.

Mr. Burgess. Okay. You know, and it is sort of a recurrent theme throughout the entire panel. I mean, things are written into stone, Mr. Morrison. Things are written into Federal law, and, yet, the world moves much faster. The real world is -- it requires a great deal more adaptability.

And I appreciate all of you being here this morning. We have heard some compelling testimony from a number of different aspects as to the delivery of healthcare, about how best of intentions have made your lives more difficult. And as a consequence, the patients on the receiving end have suffered.

Dr. Kissela, I just want to probably finish up with you. I mean, Mr. Griffith asked the important questions. 1996 was the FDA approval of TPA. Is that what you told us?

Dr. Kissela. Yes, sir.

Mr. Burgess. And then Mr. Guthrie had asked the appropriate question: Gee, how do you tell who gets what? Or you don't want to hurt anyone by giving them the TPA if they have had a hemorrhagic stroke.

I just have to tell you my own experience, 1988, and my dad had a very serious stroke. And I remember sitting there in the ICU that night wondering if that brand new drug that they were giving people with heart attacks could possibly make a difference. And, of course, no one -- no one would, you know -- you talk about an off-label

indication; no one would have gone there.

But I do remember -- I don't know if I asked about it, but I certainly thought about it. There had to be a way. Now, with what you described, and not just the clot-busting medications, but actually going in with a catheter and pulling the offending clot out and discarding it in the bedpan, I mean, a wonderful, wonderful outcome for that scenario.

Because I know the other side of that, which was almost 20 years of survival with never being able to speak a word. Ms. Bardach talks about the speech-generating devices. I became very familiar with the very rudimentary tools that were available, as my dad, who was an accomplished general surgeon, spent the rest of his life unable to communicate.

And so it is -- I mean, these are not just theoretic concerns. When Mr. Griffith brought up the Congressional Budget Office -- and, yeah, we have had a lot of discussion about the Congressional Budget Office in this committee the last 6 months, and all of it valid. And they do good work over there.

But doggone it, when you look at what you do, and they say, well, we are going to calculate, but all we can calculate is the cost, because it is the cost of the time under the C-arm, it is the time in the fluoroscopy, it is the cost of the medication, the cost of the catheters -- you really don't capture what happens way downstream.

With someone like my dad, who lives almost 20 years after the stroke, the first 10 years, you have captured all the costs. But if

you were able to prevent what happened next, the next 10 years, who knows? Maybe even continuing productive life, continuing to be a general surgeon in our little town.

So it is -- when we look at CBO stuff -- and we will have this opportunity on this committee. I feel certain that I am going to be successful in bringing this -- we look at the cost. But we have got to be able to widen out that window, not just to the 10-year budget cycle to which we are wedded currently, but we have got to have a wider look to get to the stuff that Dr. Murphy was talking about, even Dr. Ruiz was talking about. We have to have the ability to do that.

So it has been a thought-provoking morning. I want to thank all of you for spending so much time with us.

Do I have another member? I would yield to Mr. Guthrie for a followup question since I went over.

Mr. Guthrie. I am fine. I am good.

Mr. Burgess. So, seeing that there are no further members wishing to ask questions, I once again want to thank all of our witnesses for being here today.

We have received outside feedback from another number of organizations on these bills, imagine that. So I would like to submit statements from the following for the record: the National Multiple Sclerosis Society; the American Medical Association; CHIME; Health IT Now; Intermountain Health; United Surgical Partners; Steve Gleason; the ALS Association; Focus on Therapeutic Outcomes, Incorporated; the NARA; the NASL; the Private Practice Section of the APTA; PTPN; the

Coalition to Preserve Rehabilitation; the Brain Injury Association of America; AMRPA; Covington; and a letter from 12 advocacy groups on prostate cancer.

So, without objection, so ordered. Those will be made part of the record.

[The information follows:]

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

Mr. Burgess. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record.

And I will just tell you: I have several that I went way over my time, but I still have multiple questions that I am going to be submitting.

I ask the witnesses submit their response within 10 business days upon receipt of the questions.

And, without objection, the chair again thanks our witness panel for a very, very informative morning and afternoon. The subcommittee stands adjourned.

[Whereupon, at 1:13 p.m., the subcommittee was adjourned.]