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ONE HUNDRED EIGHTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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November 8, 2023

Dr. Meena Seshamani, MD, PhD
Director, Center for Medicare
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Seshamani:

Thank you for appearing before the Subcommittee on Health on Thursday, October 19, 2023, to testify at the hearing entitled "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, November 22, 2023. Your responses should be mailed to Jolie Brochin, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Jolie.Brochin@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Brett Guthrie
Chair
Subcommittee on Health

cc: Anna Eshoo, Ranking Member, Subcommittee on Health

The Honorable Earl L. "Buddy" Carter

1) Dr. Seshamani - What can CMS do to improve the availability of specialty-developed APMs, and how will the agency make sure that other models, like ACOs, provide relevant, meaningful engagement opportunities for specialists?

2) Dr. Seshamani - Considering the low participation of surgical specialties in alternate payment models and the goal of moving everyone to an APM by 2030 – how is CMS working to ensure greater APM participation across all medical specialties?

3) Dr. Seshamani - when Congress first passed a law to create Medicare's home infusion benefit, the Congressional Budget Office estimated that Medicare would produce significant savings for taxpayers and patients by transitioning millions of infusions from institutional facilities to the home setting. However, as we've seen in the data released by your agency, that transition simply hasn't happened. Given the potential benefits for both cost savings and patient quality of life, will your agency commit to working with Congress to address the challenges that have limited the availability of home infusion services?

The Honorable John Joyce

Dr. Seshamani – Recently, CMS had to intercede and ensure that on October 1, three Medicare Administrative Contractors did not implement new Local Coverage Determinations (LCDs) that would have cut off Medicare patient access in Pennsylvania and 14 other states to more than 100 products within the "skin substitutes" category, including some products that are leaders in the marketplace and that have for several decades substantially helped diabetic patients with chronic wounds. One stakeholder concern was that some restrictions only appeared in the final LCD and offered no opportunity for public comment.

I am grateful that CMS Headquarters convinced its contractors to withdraw the LCDs and to restart the rulemaking process. It seems quite inefficient for these contractors to go down a problematic pathway and to start to cause providers to change their ordering habits just to pull back at the last minute.

1) Do you believe that your regional contractors are taking sufficient care when they develop new LCDs and that they are engaging in sufficient stakeholder discussions before finalizing their new regulations?
2) Are you confident that the three contractors will avoid taking the same approach as they revisit this LCD issue in the coming months?

The Honorable Dan Crenshaw

Dr. Seshamani, the CMS Innovation Center found that only six of the more than 50 models it tested in its first decade produced statistically meaningful financial savings. Is there a systemic or programmatic reason for this?

1) Do you see promise in direct contracting for Medicare and the models that currently take this approach? Will that help with savings?

The Honorable Diana Harshbarger

Dr. Seshamani: In its final 2024 IPPS rule, the Centers for Medicare & Medicaid Services (CMS) recently restored program integrity protections for Physician-Owned Hospitals, emphasizing that it is important for the Agency to continue: "protecting the Medicare program and its beneficiaries, as well as Medicaid

beneficiaries, uninsured patients, and other underserved populations, from harms such as overutilization, patient steering, cherry-picking, and lemon-dropping."

1) In your view, would **the discussion draft legislation before the subcommittee** in effect reverse your recent actions and how would this impact quality of care in rural communities?

Dr. Seshamani: A central goal of MACRA was to move us away from a fee-for-service health care model to a system of value-based payment through the use of alternative payment models. Unfortunately, many specialty physicians wishing to move beyond fee-for-service will find that not a single physician-focused alternative payment model is available because none of the models approved by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) have been tested as proposed. While numerous proposals have been recommended for testing or implementation by the PTAC, CMMI has not moved forward with any of them.

2) Dr. Seshamani, how can Congress move the needle to make sure value-based care models for specialty medicine are put into practice?

The Honorable Mariannette Miller-Meeks

1) Dr. Seshamani, while I understand that you likely cannot answer fully today, I am concerned that a lot of our joint efforts towards value-based care may have had an unintended effect of consolidation in the physician community. Can you assure me that CMS is working to ensure that the dollars allocated by Congress for APM bonuses, which result from the quality work of physicians, are going actually benefiting those doctors who are participating in these models, rather than to the entities such as hospitals or insurers that either employ them or contract with them in those models?

2) Dr. Seshamani, over 66 million Medicare beneficiaries receive services under the DMEPOS benefit. The benefit allows patients to receive medically needed treatments such as oxygen, wheelchairs, and medical supplies in the comforts of their homes, keeping them out of expensive in-patient settings such as hospitals and nursing facilities. Due to the implementation of the DMEPOS competitive bidding program, which applied pricing derived from highly populated competitive bidding areas to all areas of the country, there has been a significant decrease in payment rates which caused a significant number of DMEPOS location closures. Just this last year, about 11% of DMEPOS locations closed, furthering diminishing beneficiary access to DMEPOS suppliers. The loss ultimately leads to far less patient access and choice. The bid program was put on hold in 2018 due to a need to update the bidding process and it was put on hold again in 2020 due to no additional savings. In all, the bid program has been on hold for the last 5 years, resulting in DMEPOS payments continuing to be based on rates from the flawed bidding program. My legislation. H.R.5555, which I am proud to be leading with Congressman Tonko, would provide much needed rate relief in former bid areas and non-rural areas, which will help protect patient access to cost-effective home-based care. Will CMS commit to working with me on this important issue?

The Honorable Debbie Dingell

As we focus on improving patient access to care, I want to talk about how we're working to expand access to health care beyond a traditional doctor's office or hospital setting. The fact is— patients don't want to have to travel to a doctor's office when they don't have to. And this is especially true for patients with cancer, heart failure, autoimmune disease, and other conditions who may need routine treatments over the course of an extended period. However, despite Congress' intent, the Centers for Medicare and Medicaid Services have improperly implemented the benefit for Medicare Part B home infusion drugs by requiring a

nurse to be physically present in the patient's home in order for providers to be reimbursed. As a result, provider participation in this important benefit has dropped, and beneficiaries have experienced reduced access to home infusion.

1) Dr. Seshamani, how does access to home-based care — and specifically, home infusion — fit into the agency's approach to expanding patient access to medical care for Medicare beneficiaries? When you look at the commercial market, private insurance plans are recognizing that access to home infusion services is vital to maintaining quality of life for patients with transportation challenges, mobility issues, and those living in rural settings who are unable to easily access traditional health care centers.
2) Dr. Seshamani, data released by your agency in both the 2022 and 2023 Home Infusion Therapy Monitoring Reports suggest that Medicare is lagging significantly behind the commercial market in promoting access to home infusion services. Can you commit to working with Congress to address these gaps in access which appear to be unique to the Medicare program?
3) Dr. Seshamani, can you briefly elaborate on any current models of care that help high needs and home-bound populations receive the personalized care services they need?

The Honorable Annie Kuster

1) I understand that the Medicare Clinical Laboratory Fee Schedule covers testing for critical conditions such as diabetes, heart disease, cancer, and infections. Do you think continued access to clinical lab tests is important for ensuring doctors have the information they need to provide care? Additionally, what would happen to payment for these laboratory services, under the fee schedule, if Congress does not pass the Saving Access to Laboratory Services Act?
2) Pharmacists have played an important role in delivering vaccines and medications, particularly in underserved and rural areas, throughout the COVID-19 pandemic. The Equitable Community Access to Pharmacist Services Act would create a Medicare reimbursement pathway for pharmacists in states that already allow them to deliver such services. Do you agree that advancing such legislation fits well within the goal of improving patient access to care for Medicare patients?

The Honorable Nanette Diaz Barragán

1) Dr. Seshamani, year after year, we are hearing growing concerns that the Medicare program is consistently implementing policies that result in cuts to reimbursement under Medicare's physician fee schedule for equipment intensive therapies, such as radiation therapy for the treatment of cancer. We understand that nearly two-thirds of all new cancer cases are diagnosed in the Medicare population. What are the steps, if any, that CMS can take to ensure there is adequate reimbursement for radiation oncology treatments to protect patient access to radiation therapy in all communities across the United States, including low-income communities?
2) Dr. Seshamani, we are hearing concerns that Medicare's hospital programs for innovative technologies—the transitional pass-through program in the hospital outpatient setting and the new technology add-on payment (NTAP) program in the hospital inpatient setting—have failed to embrace new technologies used to treat cancer patients with radiation therapy. What steps can CMS take to protect Medicare beneficiaries who require access to transformative innovations in radiation therapy under the Medicare program?