



MAR -6 2014

Administrator
Washington, DC 20201

The Honorable Andy Harris, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Dr. Harris:

Thank you for your letter sharing your concerns regarding the recent changes related to physician payment for epidural injections. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

We understand that these changes will result in payment reductions and want to explain our rationale. These changes were made as part of our efforts to improve payment accuracy by reviewing potentially misvalued codes. We began this initiative in response to concerns raised by Congress, the Medicare Payment Advisory Commission and others. Potentially misvalued codes are reviewed with input from the American Medical Association/Specialty Society Resource-Based Relative Value Scale Update Committee (AMA RUC) and public stakeholders. Each year since 2009, we have identified codes for review by looking for codes with specific attributes, such as those originally valued as inpatient services but that are typically furnished on an outpatient basis, services frequently billed together in one encounter, and high expenditure services that have not been recently reviewed.

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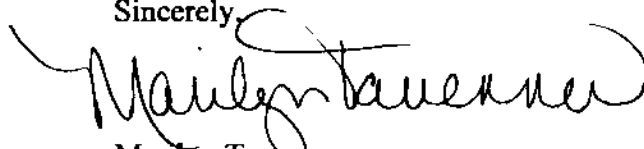
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Page 2 – The Honorable Andy Harris, M.D.

We understand that this and other changes in the physician fee schedule are expected to result in some interim CY 2014 payment reductions for services previously identified as potentially misvalued. However, we believe that it is critical to continue to refine Medicare payments to more accurately pay for physicians' services.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

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Marilyn Taveener



MAR - 6 2014

Administrator
Washington, DC 20201

The Honorable Bill Cassidy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cassidy:

Thank you for your letter sharing your concerns regarding the recent changes related to physician payment for epidural injections. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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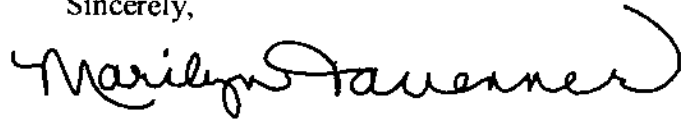
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Marilyn Tavenner



MAR - 6 2014

Administrator
Washington, DC 20201

The Honorable Phil Gingrey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

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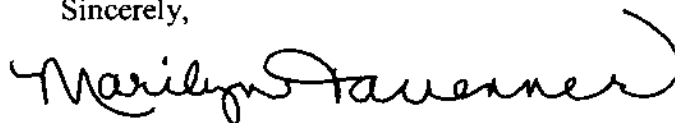
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Marilyn Tavenner



MAR - 6 2014

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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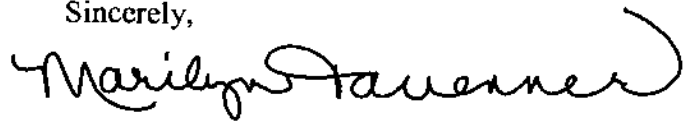
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Page 2 – The Honorable Tom Price

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Administrator
Washington, DC 20201

MAR - 6 2014

The Honorable Dan Benishek
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek:

Thank you for your letter sharing your concerns regarding the recent changes related to physician payment for epidural injections. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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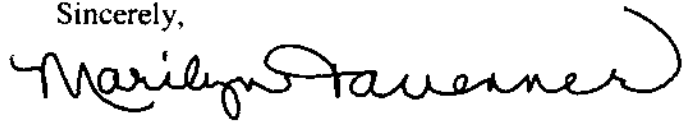
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The Honorable David P. Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

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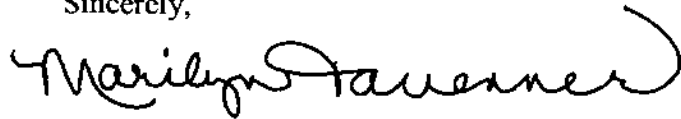
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The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

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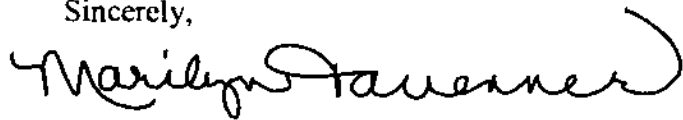
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The Honorable Michael Burgess
U.S. House of Representatives
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Dear Representative Burgess:

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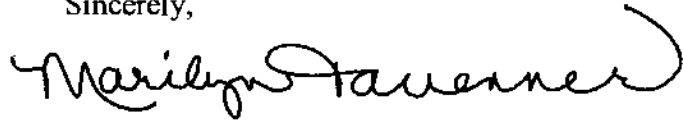
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Page 2 – The Honorable Michael Burgess

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MAR - 6 2014

Administrator
Washington, DC 20201

The Honorable Joe Heck
U.S. House of Representatives
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Dear Representative Heck:

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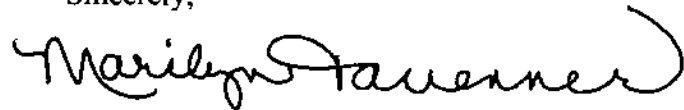
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Marilyn Tavenner

ANDY HARRIS, M.D.
FIRST DISTRICT, MARYLAND



1533 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
PHONE: 202.225.5311

COMMITTEE ON APPROPRIATIONS

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EDUCATION

100 OLDE POINT VILLAGE, SUITE 101
CHESTER, MARYLAND 21619
PHONE: 410.643.5425

LEGISLATIVE BRANCH

Congress of the United States
House of Representatives
Washington, DC 20515

WWW.HARRIS.HOUSE.GOV

January 23, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Marilyn.Tavenner@cms.hhs.gov

Dear Administrator Tavenner:

We, the undersigned members of the House GOP Doctors Caucus, are writing regarding the rules for physician payments, hospital outpatient and ambulatory surgical center payments, which were published on November 27, 2013 to be effective January 1, 2014. We are concerned this rule will impact beneficiaries' access to interventional pain management while driving patients to seek treatment in a more expensive setting.

Included in this final rule was a cut to epidural injections with a 36% reduction for physician payment and 58% reduction for procedures performed in an office setting. Specifically, we are concerned with CPT® Codes 62310, 62311, 62318, 62319.

Unless CMS addresses the underpayment for these interventional pain management services as soon as possible, there is a major risk of beneficiaries losing access to interventional pain physicians.

We do not believe the policies proposed in the MFPS rules are in the best interest of patients or taxpayers and would urge you to overturn or delay the final rule.

Thank you for your attention to this important matter. Please contact Chris Meekins in Congressman Andy Harris' office if you have any questions.

Sincerely,

Andy Harris, M.D.
Member of Congress

Bill Cassidy

Joe Heck

Phil Gingrey

Thomas R.

De Bink

Dan P. R.

René Allin

J. R. R. 11/13



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAR 11 2011

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Dr. Price:

Thank you for your letter regarding the requirement to have laboratory test requisitions signed by a physician or qualified non-physician practitioner. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

In the November 29, 2010, Medicare Physician Fee Schedule final rule, CMS finalized its proposed policy to require the ordering physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule (CLFS) effective January 1, 2011. A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

Subsequent to the final rule, CMS issued a statement on its Web site expressing concern that some physicians, NPPs, and clinical diagnostic laboratories may not be aware of or understand this policy. As such, CMS stated that it would focus its efforts in the first quarter of 2011 on developing outreach materials to educate those physicians and suppliers affected by this policy. CMS stated that these materials would be posted on its Web site, as well as through other channels, to ensure that the information would be widely distributed. CMS also stated that, once the first quarter educational campaign is fully underway, we would expect requisitions to be signed.

In recent weeks, however, CMS has been asked to rescind the policy requiring a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid under the CLFS. CMS policy officials have publicly expressed their support for rescinding the requirement. We are currently researching whether a regulation rescinding the requirement could be published before April 1, 2011.

I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

Donald M. Berwick, M.D.

Congress of the United States
Washington, DC 20515

February 10, 2011

CmTm-8-89

02/11/2011/027

DUE - 2-28-11

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8013

RECEIVED
FEB 11 2011
OSORA, DIVISION
OF CORRESPONDENCE MANAGEMENT

Dear Dr. Berwick:

We write you today regarding the Centers for Medicare and Medicaid Services (CMS) requirement included in the 2011 Medicare Physician Fee Schedule Final Rule that laboratory requisition forms be signed by the ordering physician. We ask that CMS consider delaying enforcement of the requirement, possibly for an additional nine months.

While CMS' granting of a three-month delay in enforcement of the requirement is appreciated, we believe more time is needed for CMS to work with physicians and the lab community on this rule and to discuss the potentially serious implications on patient care and business practice.

Under this new policy, laboratories will face a difficult decision when they receive a patient specimen with an unsigned requisition. Laboratories will have to decide not to provide their needed services and therefore be unable to provide a physician the information necessary to make health care decisions - or - provide the services without a guarantee of payment and then work to obtain signatures in order to submit claims to Medicare. As you can imagine, in the former situation, care may be significantly delayed; in the latter scenario the laboratories who serve a high percentage of Medicare beneficiaries could spend a large amount of time contacting providers to gather the required signatures and could see their payments delayed or face the possibility of being unable to receive payment.

We are also concerned with how this requirement will work under varying scenarios. In patient service centers, care may be delayed for patients who report to the facility with an unsigned requisition and are asked to return to the physician to obtain the required signature. In a skilled nursing facility or home health setting, where the attending physician is often not on site, and where some patients require frequent lab tests, the requirement to obtain a signature on a requisition could become increasingly difficult since there could be a significant time lag between the order and the signature. In addition, for more patients needing immediate tests, they could be sent to the emergency room so that they may receive their lab tests quickly.

Therefore, we worry about how the rule could affect Medicare beneficiaries where such lab services are necessary for a physician to make critical decisions that affect patients' health and well-being, often under significant time constraints, and urge CMS to consider these situations as they examine this policy.

Additionally, the proliferation of electronic medical records in the coming years has the potential to transform the process and documentation of orders and requisitions, offering CMS access to standardized documentation of the physician's orders. However, challenges currently exist in the electronic ordering systems for lab tests, particularly as some physician systems do not interface with lab computer systems.

We encourage CMS to consider using the additional time requested to ensure that efforts to provide consistency in documentation are aligned with its goals for adoption of health information technology systems, which will benefit patients, providers and payers alike.

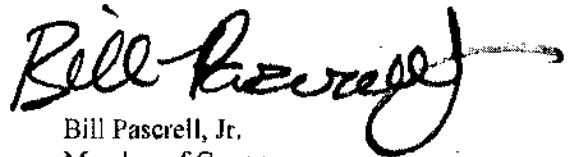
In light of these issues, we believe that additional time is necessary for CMS to work with the laboratory, physician, hospital and long-term care communities to put in place safeguards to ensure patient care is not negatively affected, allay concerns on possible payment complications stemming from this new requirement, and ensure a streamlined process for health care providers.

Thank you for your consideration of our recommendations. We look forward to hearing from you.

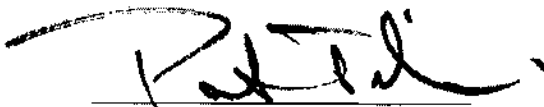
Sincerely,



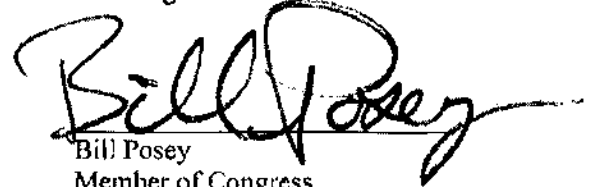
Michael C. Burgess, M.D.
Member of Congress



Bill Pascrell, Jr.
Member of Congress



Patrick J. Tiberi
Member of Congress



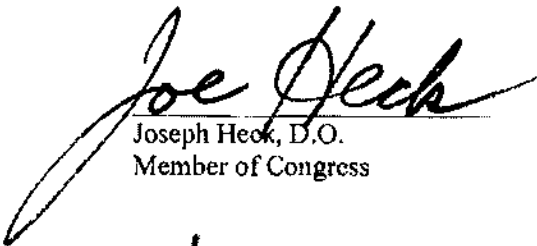
Bill Posey
Member of Congress



Rob Bishop
Member of Congress



Glenn "G.T." Thompson
Member of Congress



Joseph Heck, D.O.
Member of Congress



Ron Paul, M.D.
Member of Congress



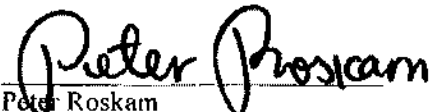
Joe Courtney
Member of Congress



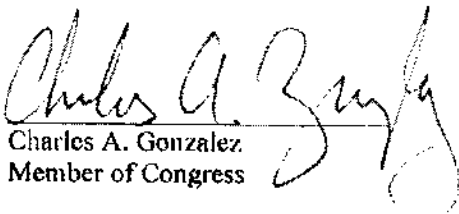
Marsha Blackburn
Member of Congress



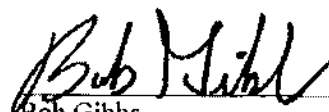
Vern Buchanan
Member of Congress



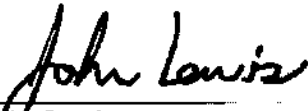
Peter Roskam
Member of Congress



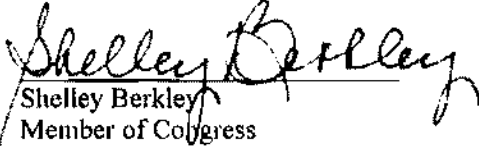
Charles A. Gonzalez
Member of Congress



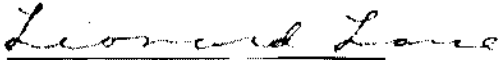
Bob Gibbs
Member of Congress



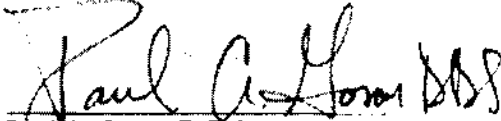
John Lewis
Member of Congress



Shelley Berkley
Member of Congress



Leonard Lance
Member of Congress



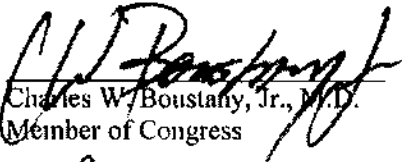
Paul A. Gosar, D.D.S.
Member of Congress




John W. Olver
Member of Congress



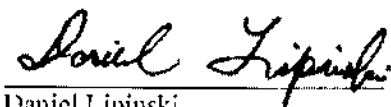
Michael E. Capuano
Member of Congress



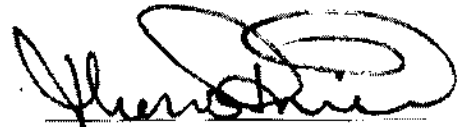
Charles W. Boustany, Jr., M.D.
Member of Congress



Renee L. Elmers
Member of Congress



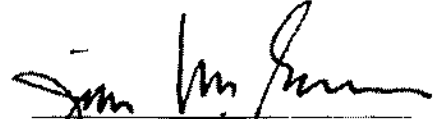
Daniel Lipinski
Member of Congress



Tom Price, M.D.
Member of Congress



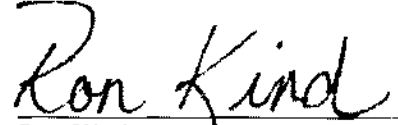
Christopher S. Murphy
Member of Congress



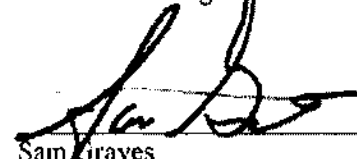
James P. McGovern
Member of Congress



Jason Chaffetz
Member of Congress



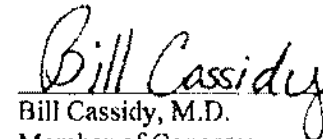
Ron Kind
Member of Congress



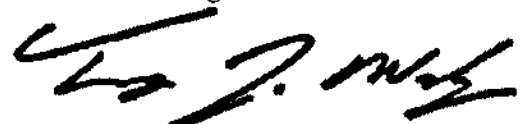
Sam Graves
Member of Congress



Diane Black RN
Member of Congress



Bill Cassidy, M.D.
Member of Congress



Timothy J. Walz
Member of Congress

Shelley Moore Capito
Shelley Moore Capito
Member of Congress

Todd L. Platts
Todd Russell Platts
Member of Congress

Paul C. Broun
Paul C. Broun, M.D.
Member of Congress

Frank Pallone, Jr.
Frank Pallone, Jr.
Member of Congress

Jo Bonner
Jo Bonner
Member of Congress

Tom Petri
Thomas E. Petri
Member of Congress

Mike Ross
Mike Ross
Member of Congress

Richard Hanna
Richard Hanna
Member of Congress

Stephen F. Lynch
Stephen F. Lynch
Member of Congress

Lee Terry
Lee Terry
Member of Congress

John P. Sarbanes
John P. Sarbanes
Member of Congress

Steve Israel
Steve Israel
Member of Congress

Phil Gingrey
Phil Gingrey, M.D.
Member of Congress

Tom Latham
Tom Latham
Member of Congress

Michael G. Grimm
Michael G. Grimm
Member of Congress

Michael T. McCaul
Michael T. McCaul
Member of Congress

Collin C. Peterson
Collin C. Peterson
Member of Congress

Erik Paulsen
Erik Paulsen
Member of Congress

Tim Murphy
Tim Murphy
Member of Congress

C.A. Dutch Ruppersberger
C.A. Dutch Ruppersberger
Member of Congress

Michael H. Michaud

Michael H. Michaud
Member of Congress

Trike

Michael G. Fitzpatrick
Member of Congress

Edward J. Markey

Ed Markey
Member of Congress

Eliot L. Engel.

Eliot L. Engel
Member of Congress

Howard Coble

Howard Coble
Member of Congress

Richard E. Neal

Richard E. Neal
Member of Congress

Mac Thornberry

Mac Thornberry
Member of Congress

Jo Ann Emerson

Jo Ann Emerson
Member of Congress

Edolphus "Ed" Towns

Edolphus "Ed" Towns
Member of Congress

Pete Sessions

Pete Sessions
Member of Congress

Barney Frank

Barney Frank
Member of Congress

Nydia Velázquez

Nydia Velázquez
Member of Congress

Steven R. Rothman

Steven R. Rothman
Member of Congress

Abio Sires

Abio Sires
Member of Congress

Charles B. Rangel

Charles B. Rangel
Member of Congress

Cathy McMorris-Rodgers

Cathy McMorris-Rodgers
Member of Congress

K. Michael Conaway

K. Michael Conaway
Member of Congress

Jim Gerlach

Jim Gerlach
Member of Congress

Martin Heinrich
Member of Congress

Gus Bilirakis
Member of Congress

Gregg Harper
Member of Congress

Steve Stivers
Member of Congress

Greg Walden
Member of Congress

John F. Tierney
Member of Congress

John R. Carter
Member of Congress

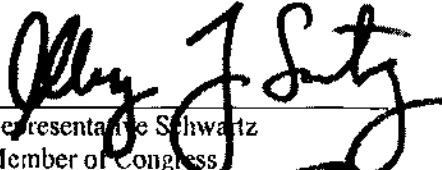
John Kilne
Member of Congress

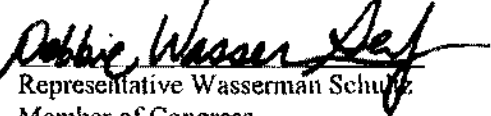
Tim Bishop
Member of Congress

John D. Dingell
Member of Congress

Carolyn McCarthy
Member of Congress


Betty McCollum
Member of Congress


Representative Schwartz
Member of Congress


Representative Wasserman Schultz
Member of Congress


Representative Miller
Member of Congress


Representative Loebsack
Member of Congress


Representative Hunter
Member of Congress


Representative Dent
Member of Congress


Representative Hanabusa
Member of Congress

Young, Sheila L. (CMS/OSORA)

From: Nixon, Karen E. (CMS/OSORA)
Sent: Friday, February 11, 2011 10:20 AM
To: Young, Sheila L. (CMS/OSORA)
Cc: Bailey, Glenda G. (CMS/OSORA)
Subject: FW: Letter to Dr. Berwick Physician Lab Signature
Attachments: Burgess-Pascrell to CMS Phys Lab Sig.pdf

Importance: High

Please control. Thanks

From: Massey, Beverly A. (CMS/OL)
Sent: Friday, February 11, 2011 10:09 AM
To: Nixon, Karen E. (CMS/OSORA); Bailey, Glenda G. (CMS/OSORA)
Cc: Khalid, Zunaira (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: FW: Letter to Dr. Berwick Physician Lab Signature
Importance: High

Good A.M. OSORA, pls control the attached Congressional Delegation letter.

thanks

From: Cones, Kenneth (CMS/OL)
Sent: Friday, February 11, 2011 9:49 AM
To: Massey, Beverly A. (CMS/OL); Khalid, Zunaira (CMS/OL)
Subject: FW: Letter to Dr. Berwick Physician Lab Signature
Importance: High

Hi Beverly and Zunaira,

Can you make sure that the attached letter gets controlled into the SWIFT system?

Thanks

From: Hall, Amy (CMS/OL)
Sent: Friday, February 11, 2011 9:45 AM
To: Clapton, Erin M. (CMS/OL); Martino, Maria (CMS/OL); Cones, Kenneth (CMS/OL); Burney, Ira (CMS/OL)
Subject: Fw: Letter to Dr. Berwick Physician Lab Signature
Importance: High

Fyi and will you get to swift?

From: Paluskiewicz, James [<mailto:James.Paluskiewicz@mail.house.gov>]
Sent: Friday, February 11, 2011 09:43 AM
To: Hall, Amy (CMS/OL)
Cc: 'Boyer, Jennifer (Roberts)' <Jennifer_Boyer@roberts.senate.gov>; Palmer, Emma (Menendez) <Emma.Palmer@menendez.senate.gov>; Hacking, Rose <Rose.Hacking@mail.house.gov>; Long, Ryan <Ryan.Long@mail.house.gov>; O'Shea, John <John.OShea@mail.house.gov>
Subject: Letter to Dr. Berwick Physician Lab Signature

Amy,

Happy Friday! I just wanted to electronically send along a letter that we sent out yesterday asking CMS to further review issues surrounding the new requirement that a physician signature on lab requisitions, or the forms used to accompany a patient specimen after it is drawn be included. A Senate companion is forthcoming. Please contact myself or Rose in Mr. Pascrell's office if you have any questions regarding the House letter.

Best,

JP

James "J.P." Paluskiewicz
Deputy Chief of Staff
Congressman Michael C. Burgess, M.D. (TX-26)
2241 RHOB
Washington, D.C. 20515
202-225-7772



APR 14 2016

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the reductions in payment rates included in the calendar year (CY) 2016 physician fee schedule (PFS) final rule for several surgical and procedural codes. You also expressed concern about the opportunity for public comment on these payment rates. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these views to our attention.

Your letter is expressing concerns about the misvalued code initiative. We use a variety of mechanisms to identify codes as potentially misvalued and seek public comment before finalizing each year's list of potentially misvalued codes. Generally, we receive recommendations for the revaluation of potentially misvalued codes from the American Medical Association/Specialty Society Relative Value Update Committee (RUC). Upon receipt of these recommendations, CMS considers the recommendations and assigns a work relative value unit (RVU) to the codes. Work RVUs reflect both time and intensity. In the absence of data or other information demonstrating that the intensity of the work involved in furnishing specific codes has changed, CMS has revised work RVUs consistent with the survey information showing that the time involved has changed.

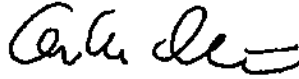
We understand your concerns about revaluations of misvalued codes that appear for the first time in the final rule with comment period. Recognizing these concerns, in rulemaking for CY 2015, CMS changed the process for valuing new, revised, and misvalued codes. We are now including proposed revaluations to address misvalued codes in the PFS proposed rule rather than including them as interim values for the first time in a final rule. After considering public comments on our proposal to revise the process for valuing codes, we adopted the revised process effective for CY 2017 code valuations. For CY 2016, we included proposed valuations for those codes for which we received RUC recommendations by February 10, 2015, in the CY 2016 proposed rule.

Because CY 2016 was a transition year, codes for which we did not receive RUC recommendations by February 10, 2015, were valued under the previous process, meaning that we established interim final values in the CY 2016 final rule with a 60-day comment period, and with a January 1, 2016, effective date. CMS staff is reviewing the public comments submitted during the 60-day comment period on the CY 2016 final rule to prepare responses for the CY 2017 proposed rule. The CY 2017 proposed rule, in turn, will be subject to public comment so there will be two public comment periods on codes revalued with interim final values in the CY 2016 final rule.

Page 2 – The Honorable Tom Price

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any other thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt". The signature is fluid and cursive, with a long horizontal stroke at the end.

Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

February 29, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RECEIVED

MAR - 7 2016

OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Acting Administrator Slavitt:

As medical providers and members of Congress, we are writing to express our deep concerns over significant reductions made to several surgical and procedural codes in the 2016 interim final Medicare physician fee schedule. We understand Center for Medicare and Medicaid Services (CMS) is in the process of identifying and correcting “misvalued” codes, but we are concerned about the magnitude of these cuts – which threaten patients’ access to care – as well as the process by which they were made.

As we understand it, the approach used by CMS in setting payment for certain services was based solely on the time it takes to perform the procedure and fails to take into account the intensity of the physician service. This would appear to be in opposition to the plain language in Sec. 1848. [42U.S.C. 1395w-4] (a) (i), which states: “The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time **and** intensity required in furnishing the service.” Intensity is defined as the technical skill and physical effort, mental effort and judgment as well as the psychological stress associated with the iatrogenic risk to the patient.

For every physician service, the intensity of work varies substantially, and as time gets shorter for intraservice work, intensity may increase. The approach adopted by CMS has not been validated, is not supported by medicine and Congress has not mandated this change. We are concerned that CMS will continue applying this flawed methodology to other physician services.

We also understand that CMS rejected recommendations by the Relative Value Update Committee (RUC), which recommended work values that would have resulted in significant, but more appropriate, payment cuts to these procedures. The RUC also took into consideration survey data from experienced physicians as well as the time and intensity of all aspects of the service (e.g., pre-operative and post-operative work). The CMS cuts go well-beyond the RUC recommended cuts and are not consistent with a resource-based relative value payment system.

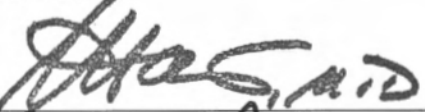
In addition, Congress has called for increased transparency through notice and comment rulemaking when making such significant payment changes. Given the timing of the interim final rule, as well as the magnitude of some of the cuts, we find it unacceptable that CMS did not provide any opportunity for public comment to be taken into consideration before many of these extraordinary payment cuts took effect on January 1, 2016. No physician should receive such drastic cuts without the chance to provide feedback comment.

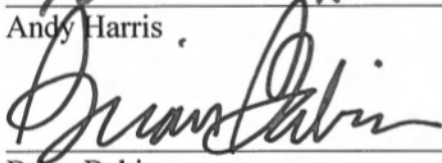
030720164078


We strongly urge you to review these cuts, particularly in light of the recommendations from the RUC, and consider the potential impact of how CMS determined the cuts that appear to introduce an arbitrary new reimbursement model, based solely on time.

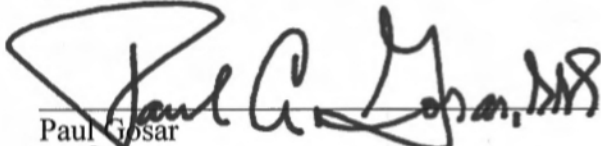
Sincerely,

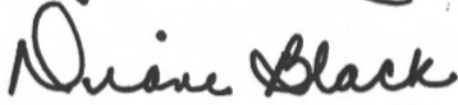

David P. Roe


Andy Harris


Brian Babin

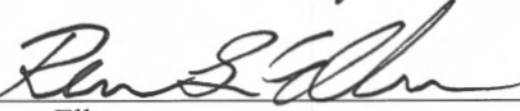

Dan Benishek



Paul Gosar

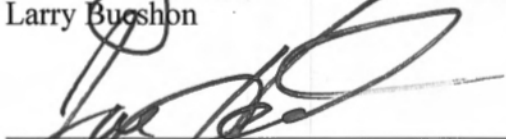

Diane Black

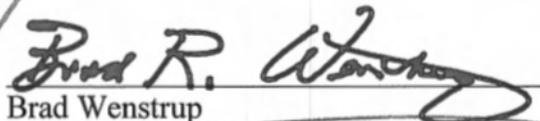

Mike Simpson


Charles Boustany

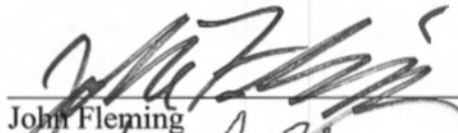

Renee Ellmers

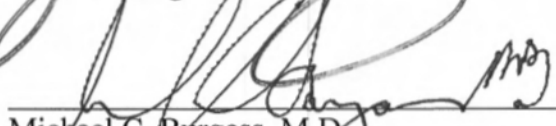

Larry Bucshon


Joe Heck, D.O.

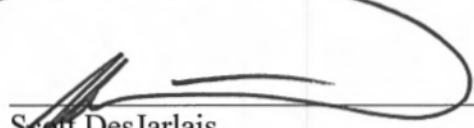

Brad Wenstrup


Tom Price


John Fleming


Michael C. Burgess, M.D.


Ralph Abraham


Scott DesJarlais



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Jerry Moran
House of Representatives
Washington, DC 20515

Dear Representative Moran:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

The NPRM on the meaningful use of EHRs and the IFR on the standards and certification criteria for EHRs were published on January 13, 2010. The comment period for both the NPRM and the IFR ended on March 15, 2010. I can assure you that we will consider your concerns and other comments addressing these regulations very carefully before deciding upon the policies to be included in both final rules, which we expect to publish later this year.

Thank you again for your letter. I share your commitment to establishing a robust national health infrastructure that supports the adoption of EHRs that can help health care providers practice safer and more effective medicine, and I appreciate your interest in this important issue. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator



Administrator
Washington, DC 20201

APR 14 2010

The Honorable Christopher Murphy
House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Sincerely,

A handwritten signature in cursive script that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Scott Murphy
House of Representatives
Washington, DC 20515

Dear Representative Murphy:

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Sincerely,

A handwritten signature in cursive script that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Sue Myrick
House of Representatives
Washington, DC 20515

Dear Representative Myrick:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Jerrold Nadler
House of Representatives
Washington, DC 20515

Dear Representative Nadler:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Grace Napolitano
House of Representatives
Washington, DC 20515

Dear Representative Napolitano:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Richard Neal
House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Randy Neugebauer
House of Representatives
Washington, DC 20515

Dear Representative Neugebauer:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Charlene Frizzera
Acting Administrator



Administrator

Washington, DC 20201

APR 14 2010

The Honorable James Oberstar
House of Representatives
Washington, DC 20515

Dear Representative Oberstar:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



APR 14 2010

Administrator

Washington, DC 20201

The Honorable John Olver
House of Representatives
Washington, DC 20515

Dear Representative Olver:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



APR 14 2010

Administrator

Washington, DC 20201

The Honorable Solomon Ortiz
House of Representatives
Washington, DC 20515

Dear Representative Ortiz:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Sincerely,

A handwritten signature in black ink that reads "Charlene Frizzera". The signature is written in a cursive, flowing style.

Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator

Washington, DC 20201

The Honorable Bill Owens
House of Representatives
Washington, DC 20515

Dear Representative Owens:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Bill Pascrell
House of Representatives
Washington, DC 20515

Dear Representative Pascrell:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 14 2010

The Honorable Ron Paul
House of Representatives
Washington, DC 20515

Dear Representative Paul:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



APR 14 2010

Administrator

Washington, DC 20201

The Honorable Erik Paulsen
House of Representatives
Washington, DC 20515

Dear Representative Paulsen:

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Acting Administrator



Administrator
Washington, DC 20201

APR 14 2010

The Honorable Tom Perriello
House of Representatives
Washington, DC 20515

Dear Representative Perriello:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Gary Peters
House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Administrator
Washington, DC 20201

APR 14 2010

The Honorable Collin Peterson
House of Representatives
Washington, DC 20515

Dear Representative Peterson:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Thomas Petri
House of Representatives
Washington, DC 20515

Dear Representative Petri:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 14 2010

The Honorable Joseph Pitts
House of Representatives
Washington, DC 20515

Dear Representative Pitts:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator

Washington, DC 20201

The Honorable Todd Platts
House of Representatives
Washington, DC 20515

Dear Representative Platts:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Washington, DC 20201

APR 14 2010

The Honorable Bill Posey
House of Representatives
Washington, DC 20515

Dear Representative Posey:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Administrator

Washington, DC 20201

APR 14 2010

The Honorable David Price
House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Administrator

Washington, DC 20201

APR 14 2010

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Representative Price:

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Sincerely,

A handwritten signature in black ink that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator



APR 14 2010

Administrator
Washington, DC 20201

The Honorable Nick Rahall
House of Representatives
Washington, DC 20515

Dear Representative Rahall:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Dave Reichert
House of Representatives
Washington, DC 20515

Dear Representative Reichert:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 14 2010

The Honorable Phil Roe
House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Michael Rogers (AL)
House of Representatives
Washington, DC 20515

Dear Representative Rogers:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 14 2010

Administrator
Washington, DC 20201

The Honorable Michael Rogers (MI)
House of Representatives
Washington, DC 20515

Dear Representative Rogers:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Administrator
Washington, DC 20201

APR 14 2010

The Honorable Tom Rooney
House of Representatives
Washington, DC 20515

Dear Representative Rooney:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Peter Roskam
House of Representatives
Washington, DC 20515

Dear Representative Roskam:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Mike Ross
House of Representatives
Washington, DC 20515

Dear Representative Ross:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Steven Rothman
House of Representatives
Washington, DC 20515

Dear Representative Rothman:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



Administrator
Washington, DC 20201

APR 14 2010

The Honorable Lucille Roybal-Allard
House of Representatives
Washington, DC 20515

Dear Representative Roybal-Allard:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



Administrator
Washington, DC 20201

APR 14 2010

The Honorable C. A. Ruppertsberger
House of Representatives
Washington, DC 20515

Dear Representative Ruppertsberger:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 14 2010

The Honorable Bobby Rush
House of Representatives
Washington, DC 20515

Dear Representative Rush:

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Tim Ryan
House of Representatives
Washington, DC 20515

Dear Representative Ryan:

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Administrator
Washington, DC 20201

APR 14 2010

The Honorable Alan Mollohan
House of Representatives
Washington, DC 20515

Dear Representative Mollohan:

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Dennis Moore
House of Representatives
Washington, DC 20515

Dear Representative Moore:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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APR 14 2010

Administrator
Washington, DC 20201

The Honorable Gwen Moore
House of Representatives
Washington, DC 20515

Dear Representative Moore:

Thank you for your letter concerning regulations that the Department of Health and Human Services is promulgating to implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009. As you may know, the comment period recently closed for two HITECH rules: 1) a Notice of Proposed Rulemaking (NPRM) on the Medicare and Medicaid incentive program for the meaningful use of electronic health records (EHRs); and 2) an interim final rule (IFR) on the initial set of standards and certification criteria for EHRs.

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

Correspondence Cover Sheet

Doc ID: **031720104013** *Date Due:*
Corr. From: **Zack Space, et al.** *Task Date:*
On Behalf Of: **DELEGATION249 CONGRESSIONAL (249)**
Letter Date: **3/15/2010** *Folder Created:* **3/17/2010**

Subject: **MEANINGFUL USERS OF CERTIFIED ELECTRONIC HEALTH RECORDS(EHR)**
Synopsis: **PROPOSED DEFINITION OF AND REQUIREMENT FOR HOSPITAL TO BECOME QUALIFIED AS MEANINGFUL USERS OF CERTIFIED ELECTRONIC HEALTH RECORDS (EHR) TECHMOLOGY.**

****CONGRESSIONAL DELEGATION (249) SEE LIST FOR NAMES**

Primary Issues: **Access to Services**

Program Office Assigned:

Action Required: **Prep for Sig** *Signature Level:* **Admin Sig**
Coordinator: **Jacqueline Barnes** *Data Entry By:* **Brenda McCray**

Instructions: **None**

Please send your responses to the assigning office.

0317 2010 4013

Congress of the United States
Washington, DC 20515

OESS

March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Frizzera,

We are writing to urge you to modify your proposed definition of and requirements for hospitals to become qualified as "meaningful users" of certified electronic health record (EHR) technology. The Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding Medicare and Medicaid incentives for meaningful use of EHRs is, we fear, too much too soon for the vast majority of America's hospitals and does not take into account the progress hospitals already have made toward the goal of universal EHR adoption. Furthermore, the regulation's narrow definition of an eligible provider would preclude individual campuses of multi-campus hospitals and many physicians that CMS considers "hospital-based" from even participating in the incentive program. The proposed rule would essentially prohibit physicians providing primary care services in hospitals clinics from being eligible for the incentive program. It is our belief that it would likely result in a majority of hospitals, particularly rural and safety-net providers, being financially penalized for an inability to comply.

Meaningful Use Definition

The EHR rule goes against the intent of Congress to reward those hospitals that already have taken important steps toward implementing EHR systems and to provide incentives to encourage further development. It proposes an ambitious all-or-nothing approach in which hospitals would be required to adopt all 23 separate EHR objectives, or requirements, that very few hospitals have yet been able to accomplish. The rule should be altered to recognize a practical, staged approach to EHR adoption that rewards the efforts already underway in America's hospitals.

We strongly urge you to modify the meaningful use requirements in the rule so that it:

- Requires a narrow base of objectives in 2011 to qualify as a meaningful user of EHRs and increases the requirements over time until all required objectives are operational by 2017;
- Extends the transition to 2017 so that it mirrors the transition established for Medicare payment penalties for non-meaningful users of EHRs;

- Grandfathers certification requirements for existing systems in use for 24 months to ensure that the current delay in HHS's development of a certification process and time needed to become certified does not prevent a hospital from being considered a meaningful user;
- Includes quality reporting of measures that have been fully tested and validated for EHR reporting and for which CMS has an ability to accept in EHR form; and
- Excludes non-clinical objectives such as electronic insurance verification and claims submission that are unrelated to patient care and rely on voluntary payer participation.

Additionally, states should not be allowed to make it harder to qualify for Medicaid EHR incentive payments. The Medicaid incentives should also be considered separate and apart from other Medicaid program payments for services. Further, Critical Access Hospitals should be eligible to receive Medicaid program incentive payments if they meet the definition of meaningful use. CMS' exclusion of CAHs from the Medicaid incentive program is contrary to the statute and inappropriate.

Hospital-Based Physician Definition

Separate and apart from the issue of meaningful use, we are concerned about CMS's proposed definition of a hospital-based physician. CMS' definition is very broad and inappropriately excludes physicians practicing in outpatient centers and clinics from being eligible for EHR incentive payments merely because their office or clinic is located in a facility owned by the hospital. Implementing an EHR in the ambulatory setting requires a significant cost for the hospital above and beyond the cost of the inpatient EHR. Therefore, this broad exclusion of physicians may inhibit hospital investments in their outpatient primary care sites, which runs counter to the intent of Congress in creating EHR incentive payments. Therefore, we urge you to define a hospital-based physician so as to exclude physicians practicing in outpatient centers and clinics.


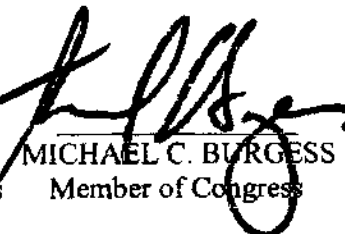
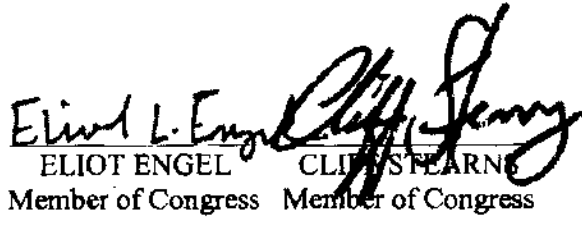

For the purposes of this EHR incentive program, CMS should modify the scope of services it considers to be outpatient hospital services. Regardless of how the ambulatory care sites are licensed or established, the care and services furnished in these settings are similar to services furnished by private physician offices in other communities that are able to attract private physicians and clearly eligible under the statute to receive HIT incentive payments. Physicians practicing in hospital ambulatory care sites, particularly those located in health shortage areas, should not be disadvantaged relative to their peers practicing in more traditional private practice settings from receiving HIT incentive payments. A broad interpretation of hospital-based physicians would inappropriately and inadvertently exclude many physicians furnishing ambulatory care services from eligibility for incentive payments and therefore, prevent patients in these communities from realizing the known benefits of EHRs such as care coordination.

Multi-Campus Hospital Limitation

In addition, the rule inappropriately limits the number of hospitals that are eligible to receive incentives and participate in the program. Specifically, CMS's proposal to use Medicare provider numbers to distinguish hospitals for EHR incentive payment purposes is not appropriate. In many facilities, a single provider number can include multiple campuses of a hospital system. If the Medicare provider number is used to define a hospital, a health care system with multiple hospital sites (but a single Medicare provider number) would receive one incentive payment for the entire health care system. This disadvantages and penalizes hospital systems with only one provider number relative to hospital systems with multiple provider numbers. For EHR incentive payment purposes, we ask that you identify hospitals as discrete facilities of service so that individual sites of hospitals are eligible to separately qualify for the incentives.

If you have any questions or wish to discuss this further, please don't hesitate to contact us directly.

Sincerely,

			
ZACK SPACE	MICHAEL C. BURGESS	ELIOT ENGEL	CLIFF STEARNS
Member of Congress	Member of Congress	Member of Congress	Member of Congress

Suzanne McKenna Tom Fether Bob Goodwater

John Duce Gene Canavan Mike Cottle

Melinda L. Deane Lucy Linn Polly J. Hill

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John →

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232. Titus, ~~Dina~~ Dina
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236. Van Hollen, Chris
237. Velazquez, Nydia
238. Walden, Greg

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- 240. Wasserman Schultz, Debbie
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- 244. Whitfield, Ed
- 245. Wilson, C., Charlie
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- 247. Woolsey, Lynn
- 248. Wu, David
- 249. Yarmuth, John



Administrator
Washington, DC 20201

MAY 09 2013

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with multiple chronic conditions. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans

achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

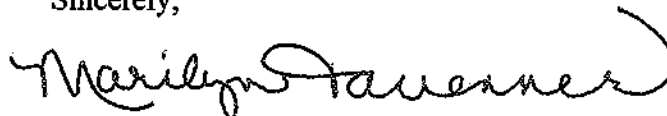
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner
Acting Administrator

Congress of the United States
Washington, DC 20515

March 15, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Tavenner:

We are concerned about the cumulative negative impact of provisions contained in the 45 Day Notice and draft Call Letter. First, proposed changes in risk adjustment will disadvantage vulnerable beneficiaries with multiple chronic conditions. Medicare Advantage (MA) plans have a proven track record when it comes to coordinating care for chronically ill individuals and this proposal will reduce their ability to continue to do so. Second, CMS' proposal with respect to the star ratings would lead to unwarranted downward shifts in the ratings. Third, CMS continues the illogical policy of assuming the scheduled 25 percent reduction in the Medicare physician fee schedule (SGR) will be implemented on January 1, 2014.

The assumption on the SGR is particularly problematic because it almost certainly will turn out to be wrong and it directly translates into lower funding to support the health benefits of the 14 million Medicare beneficiaries who currently are enrolled in MA plans. The combined effects of the Affordable Care Act (ACA) and the new payment cuts proposed by CMS in its 45 Day Notice are estimated to result in a 6.9 to 7.8 percent cut to Medicare Advantage plans in 2014. Those cuts could translate into benefit reductions and premium increases of \$50 to \$90 per month for each MA enrollee next year. This reduction in funding will leave many vulnerable seniors with fewer benefits, higher out-of-pocket costs, and in some cases the loss of their current MA coverage.


Considering these cumulative impacts, we urge you to use your authority under Sections 1853(c)(6) and 1876(a)(4) of the Social Security Act to calculate Medicare Advantage (MA) rates for 2014 based on an assumption that legislation will be enacted later this year to maintain Medicare physician payment rates at their current levels in 2014, without any reduction. CMS requires that plan sponsors incorporate likely SGR legislative fixes in their bids. It makes no sense that plans should have to incorporate this assumption while CMS does not.

Over the past decade, Congress repeatedly has approved Medicare physician payment “fixes” to block similar reductions from taking effect. These bills consistently have been passed with strong bipartisan support and we are confident that such legislation will be passed again in the 2013 session. In fact, there is growing momentum in Congress for passing legislation this year to achieve a permanent “fix” for the Medicare physician payment system.

Having closely examined the relevant statutory provisions of the Social Security Act, we believe it is abundantly clear that Sections 1853(c)(6) and 1876(a)(4) require CMS to develop “estimates” of the projected growth rate in Medicare expenditures and applicable county-specific fee-for-service costs that serve as the basis for MA rates and would permit the agency to rely on the best available information. These statutory provisions grant CMS a significant degree of flexibility in determining how to calculate estimated rates for MA payments. Based on our analysis of these provisions, we believe you have authority under current law to calculate 2014 MA rates based on an assumption that a Medicare physician payment “fix” will be enacted later this year.

The SGR assumption, in addition to the changes in risk adjustment and the star ratings, will have significant, negative impacts on the MA program. We urge you to use your administrative discretion to fix these problems that will, ultimately, only penalize beneficiaries. Thank for your attention to this important issue. We look forward to hearing from you regarding your decision.

Sincerely,

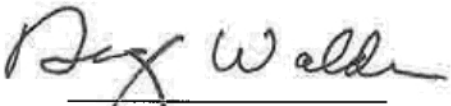

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Rep. Ron Kind


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Diane Black

Rep. Diane Black

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Rep. Larry Bucshon, M.D.

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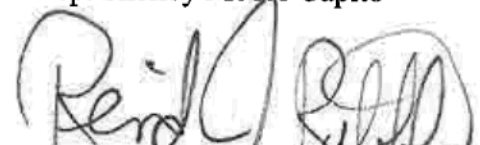

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Rep. Rich Nugent

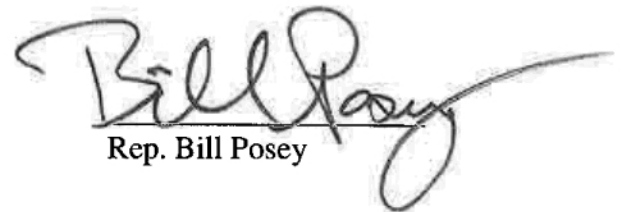

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Rep. Mike Kelly

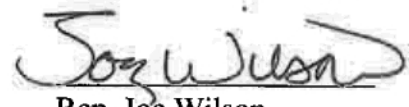

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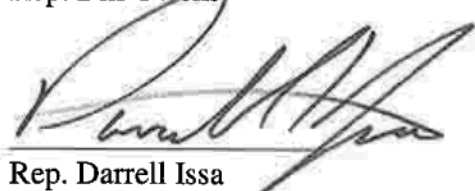

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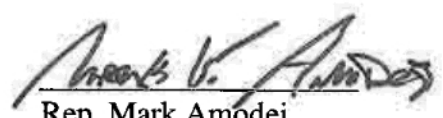

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Rep. Bill Posey


Rep. Bill Owens

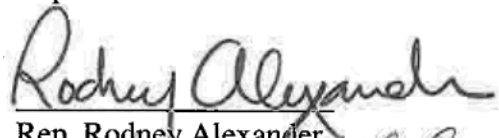

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Rep. Darrell Issa

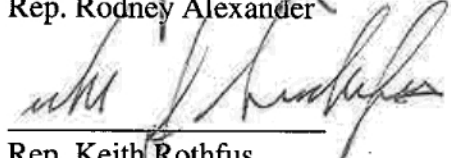

Rep. Mark Amodei

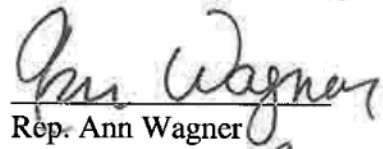

Rep. Renee Ellmers



Rep. Chris Gibson

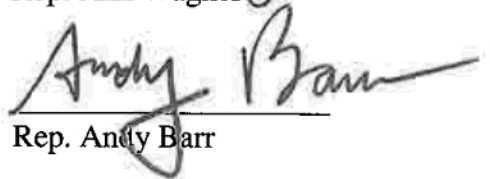

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Rep. Michael Burgess, M.D.


Rep. Keith Rothfus


Rep. Ann Wagner


Rep. Collin Peterson


Rep. Andy Barr



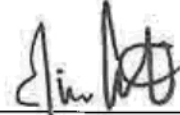
Rep. Vern Buchanan



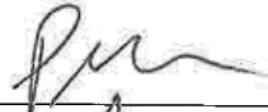
Rep. H. Morgan Griffith



Rep. Kurt Schrader



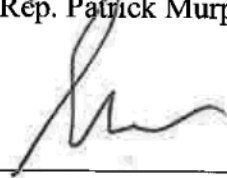
Rep. Jim Costa



Rep. Patrick Murphy



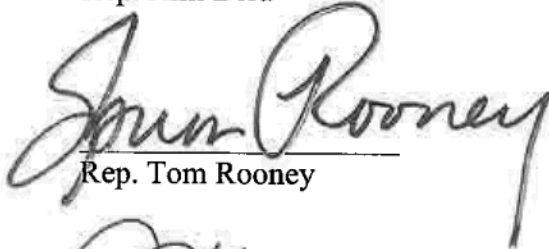
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Alan Nunnelee
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J. Randy Forbes
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Denny Heck Denny Heck

Scott Peters Scott Peters

John Shimkus John Shimkus

Rodney Davis Rodney Davis

Jeff Duncan Jeff Duncan

Eric Swalwell Eric Swalwell

Gloria Negrete McLeod
Gloria Negrete McLeod

Thomas Price
Thomas Price



Administrator
Washington, DC 20201

MAY 15 2009

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Mr. Price:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rule, CMS-2252-P, to revise regulations governing the cytology proficiency testing program mandated by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), which was published in the *Federal Register* on January 16, 2009.

The CMS, in collaboration with the Centers for Disease Control and Prevention (CDC), worked diligently to produce a proposed rule that closely reflects the recommendations of the Secretary's Clinical Laboratory Improvement Advisory Committee, and input from experts and stakeholders throughout the cytology community. The public comment period for the proposed rule closed on March 17, 2009, and we are currently reviewing the many thoughtful comments we received.

I regret that we are unable to address specific aspects of the proposed rule while this rulemaking is in progress. However, all suggestions and concerns raised by the public comments, including those noted in your letter, will be addressed in detail upon publication of a final rule.

The CMS, CDC, and the Food and Drug Administration are jointly responsible for administering CLIA, which provides important patient testing protections, including specialized standards and requirements to ensure the accuracy of Pap test interpretations. I share your concern that these provisions be implemented appropriately and we appreciate your ongoing efforts on behalf of women's health.

I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator



Congress of the United States
House of Representatives
Washington, DC 20515

March 18, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Washington, DC 20201

RECEIVED

MAR 18 2009

OSORA DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Ms. Frizzera,

We are writing regarding a recently published proposed rule by the Center for Medicare and Medicaid Services (CMS) that would make changes to the current cytology proficiency testing (PT) requirements (CMS-2252-P). We take great interest in the agency's regulatory interpretation and design of a federal cytology proficiency test and urge you to consider alternative models, such as that provided in the H.R. 1237, Cytology Proficiency Improvement Act. This legislation passed in the House of Representatives last year with strong bipartisan support.

We're concerned that the proposed rule leaves in place the same fundamentally flawed proficiency testing model established in the 1992 regulation. Both the current and proposed tests do not provide a scientifically reliable or valid measure of competency in reading Pap tests. We're equally concerned that CMS has not allowed for the consideration of alternative models in its proposed regulation. The Administration has expressed the need to ensure that regulations are guided by science and effectiveness. This proposed rule does not make that case.

As you know, in 1992, a federal cytology proficiency testing program was established by CMS (then HCFA) as part of implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA). However, it wasn't until 2005, more than a decade after the final regulation was issued, that CMS actually launched the program. In 2006, following considerable pressure from Congress, as well as the laboratory and physician community, CMS and its laboratory advisory committee, the Clinical Laboratory Advisory Committee, (CLIAC) initiated a review of the program and proposed changes. However, the CLIAC was not allowed to consider alternative testing approaches that might differ from the current regulatory model, but still meet CLIA statutory requirements, such as the Cytology Proficiency Improvement Act.

Similarly, the proposed rule does not consider alternative models. This is especially troubling given that the CLIA statute was not specific as to how proficiency should be demonstrated, and by no means mandates or suggests a particular testing regiment. In addition, recently published scientific studies, available to CMS prior to the publication of the proposed rule, concluded that the "test" cannot measure competency unless it's based on close to 100 slides. The CLIAC also heard expert testimony that an individual's ability to read Pap tests does not diminish over time. Although the proposed regulation may be well intended, it does not correct the fact that the testing model to which the changes are proposed remains inherently flawed.

We understand CMS has data regarding cytology proficiency testing results, but has provided no empirical evidence that links "test" results to competency or improved patient outcomes, such as a reduction in false positives or false negatives. Moreover, calling for a 20 slide "test" every two years instead of 10 slides annually will still not produce a meaningful or statistically valid measure of competency. The proposed changes neither take into account the federally mandated responsibilities of the laboratory director, nor recognize that performance data related to the quality and accuracy of reading Pap tests is already documented in the numerous quality measures already established under CLIA. Laboratory directors, as a matter of federal law, are already responsible for utilizing these measures in evaluating the performance of laboratory personnel and must take appropriate corrective action as necessary to ensure quality.

The alternative we support and provided in the Cytology Proficiency Improvement Act, is a far more effective and meaningful approach. It would provide a proficiency test requirement to assess and improve skills in reading Pap tests as part of a rigorous educational curriculum. This curriculum would include complex, difficult cases. In contrast, both the current and newly proposed program would not capture important "gray areas" of Pap test practice, ignoring a large segment of diagnoses that are critical to the prevention and management of cervical cancer.

It is our hope that CMS will allow for periodic reviews of the cytology proficiency testing (PT) requirements in order to continue to use alternative testing requirements and models to ensure patient safety.

Adherence to a proficiency testing model that is scientifically invalid and based on a 16-year old interpretation of the CLIA statute does not advance the fight against cervical cancer. Again, we urge you to consider alternative "testing" models to that proposed in the published rule.

Sincerely,



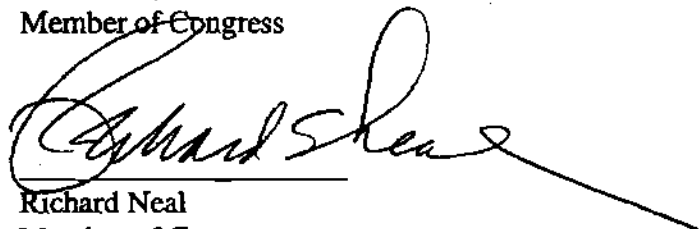
Bart Gordon
Member of Congress



Tom Price, M.D.
Member of Congress



Nathan Deal
Member of Congress



Richard Neal
Member of Congress

cc Charles E. Johnson, Acting Secretary, HHS

FACSIMILE TRANSMISSION COVER SHEET

Date: 3/17/09

To: Name: Charlene Frizzera, Acting Administrator CMS

Address: 2000 Independence Ave, DC 20201

Telecopier#: 202-690-6262 Pages: 3 (including cover sheet)

(phone: 202-225-4231 fax: 202-225-6887)

From:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Bart Gordon | <input type="checkbox"/> Rekha Chandrasekaran (LC/Sys Admin) |
| <input type="checkbox"/> Chuck Atkins (CoS) | <input type="checkbox"/> Keith Talley (Press Sec) |
| <input type="checkbox"/> David Plunkett (LD) | <input type="checkbox"/> Greg Holyfield (LA) |
| <input type="checkbox"/> Dana Lichtenberg (LA) | <input type="checkbox"/> Julie Eubank (Scheduler) |
| <input type="checkbox"/> Alisa Ferguson (LA) | <input type="checkbox"/> Erica Antonson (LC) |
| | <input type="checkbox"/> _____ |

This facsimile contains confidential privileged information intended for the person(s) to whom it is addressed. Do not read, copy or disseminate this information unless you are the addressee (or the person responsible for delivering it). If you have received this document in error, please call us immediately at (202) 225-4231, and return the original to Congressman Bart Gordon, U.S. House of Representatives, Washington, DC 20515 via mail. Thank you.



Administrator
Washington, DC 20201

APR 22 2016

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding our calendar year (CY) 2016 payment rates for glaucoma surgery and retinal detachment surgery included in CY 2016 physician fee schedule final rule. You urged us to accept the recommendations of the American Medical Association/Specialty Society Relative Value Update Committee (RUC) for these codes. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these views to our attention.

After identifying these codes as potentially misvalued, CMS received recommendations from the RUC for revaluation of these codes. CMS assigned work relative value units (RVUs) to these codes that differed from those recommended by the RUC to reflect a decrease in the time required to furnish these services since the last valuation, based on surveys conducted as part of the RUC process. In the absence of data or other information demonstrating to us that the intensity of the work involved in furnishing these codes had changed, we based the work RVUs for these codes on the new times, assuming the same intensity as under the previous valuations.

We established interim final values for these codes in the CY 2016 final rule with a 60-day comment period, and a January 1, 2016, effective date for the new values. CMS staff is in the process of reviewing the public comments submitted during the 60-day comment period on the CY 2016 final rule to prepare responses for the CY 2017 proposed rule. The CY 2017 proposed rule, in turn, will be subject to public comment.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

March 10, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RECEIVED

MAR 21 2016

OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Acting Administrator Slavitt:

We write to express our deep concerns regarding significant cuts made by the Centers for Medicare & Medicaid Services (CMS) to Medicare payments for vision-saving glaucoma and retinal surgeries. Respectfully, we request reconsideration of CMS' basis for—and decision to implement—these cuts, and urge the Agency to adopt the payment recommendations of the Relative Value Update Committee (RUC).

As you know, access to care is critical for the three million Americans living with glaucoma and many others who require emergency surgery to repair retinal detachment. The cuts implemented by CMS threaten access to treatments that are particularly important for vulnerable Medicare beneficiaries, who are at a higher risk of severe vision loss. Once lost, vision cannot be restored for patients with retinal detachments, or glaucoma, which does not have a cure. Timely treatment—including the option for surgery—is critical.

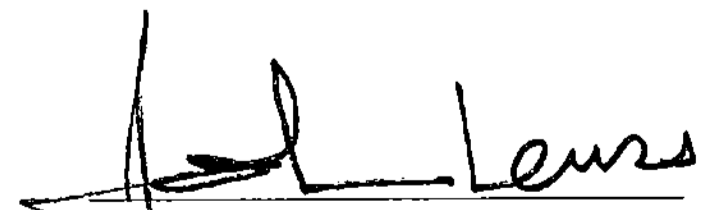
The Physician Fee Schedule interim final rule for 2016 imposed cuts of between 25 percent and 33 percent for two glaucoma surgical procedures, cuts of 32 percent and 16 percent for two procedures for repairing retinal detachments, and additional significant cuts made to other ophthalmology treatments. While Congress directed CMS to identify and correct "misvalued" codes, we are concerned with the magnitude of these cuts. Medicare statute mandates that physician fee schedule payments be based on a resource-based relative value scale (RBRVS) that considers the resource costs necessary to provide a service, including the factor of physician work based on both time and intensity. In setting this payment scale, however, it seems as though CMS considered only the time it takes to perform the procedure and failed to take into account the intensity of the physician service, as required by law.

Again, in light of the importance of these treatments to Medicare beneficiaries we implore you to both reexamine the recommendations from the RUC and to strongly consider the impact of introducing a new method of review that is based solely on time. The result appears to be unreasonably high cuts to glaucoma and other ophthalmology services that may be inaccurate as well as inappropriately implemented.

As always, we thank you for your attention to this grave matter.


PETER J. ROSKAM
Member of Congress

Sincerely,


JOHN LEWIS
Member of Congress

Pat Tiberi

PATRICK J. TIBERI
Member of Congress

Alan Grayson

ALAN GRAYSON
Member of Congress

David Scott

DAVID SCOTT
Member of Congress

Bill Flores

BILL FLORES
Member of Congress

Mike Bost

MIKE BOST
Member of Congress

Theodore E. Deutch

THEODORE E. DEUTCH
Member of Congress

Earl L. "Buddy" Carter

EARL L. "BUDDY" CARTER
Member of Congress

Gwen Moore

GWEN MOORE
Member of Congress

David B. McKinley

DAVID B. MCKINLEY
Member of Congress

Rodney Davis

RODNEY DAVIS
Member of Congress

Gus M. Bilirakis

GUS M. BILIRAKIS
Member of Congress

Ruben Hinojosa

RUBÉN HINOJOSA
Member of Congress

Vern Buchanan

VERN BUCHANAN
Member of Congress

Lynn Jenkins

LYNN JENKINS, CPA
Member of Congress

Robert J. Dold

ROBERT J. DOLD
Member of Congress

H. Morgan Griffith

H. MORGAN GRIFFITH
Member of Congress

Charles B. Rangel

CHARLES RANGEL
Member of Congress

Peter DeFazio


PETER DEFAZIO
Member of Congress

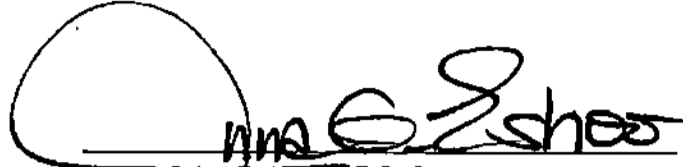
George Holding

GEORGE HOLDING
Member of Congress

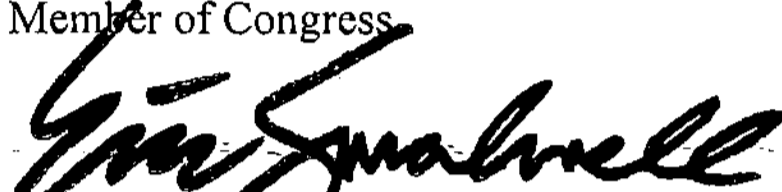
Mike Kelly

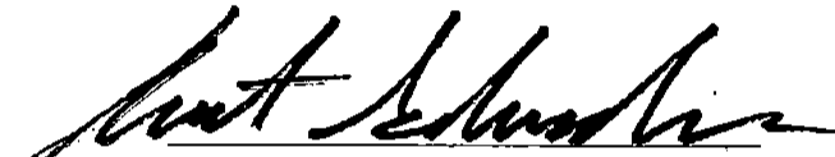
MIKE KELLY
Member of Congress


DONALD M. PAYNE, JR.
Member of Congress



ANNA G. ESHOO
Member of Congress

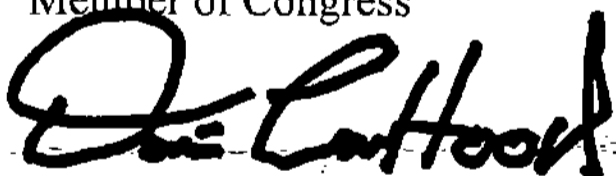

BILL JOHNSON
Member of Congress

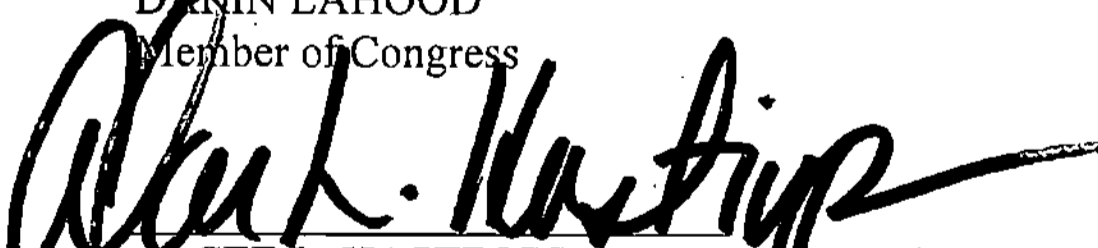

ERIC SWALWELL
Member of Congress

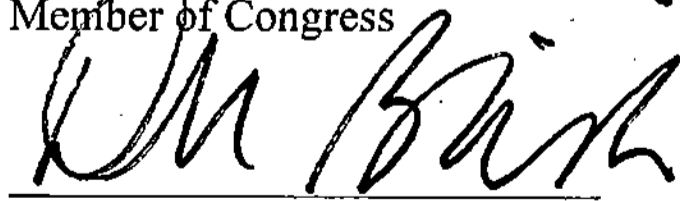

KURT SCHRADER
Member of Congress



MIKE FITZPATRICK
Member of Congress



RICK W. ALLEN
Member of Congress

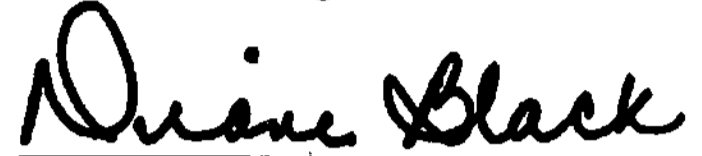

DARIN LAHOOD
Member of Congress

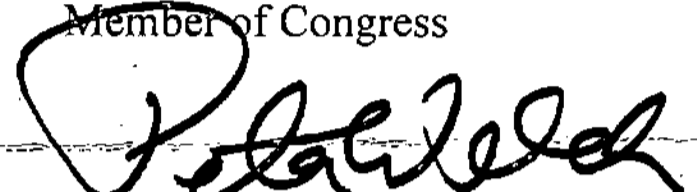

ALCEE L. HASTINGS
Member of Congress

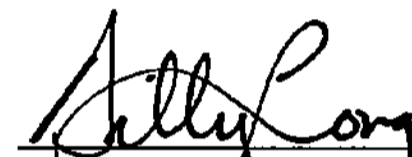

DAN BENISHEK
Member of Congress

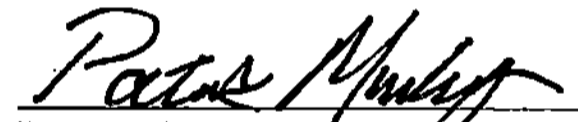

PETE AGUILAR
Member of Congress



TOM PRICE, M.D.
Member of Congress



DIANE BLACK
Member of Congress

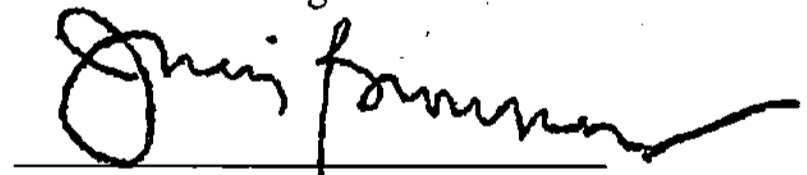

PETER WELCH
Member of Congress

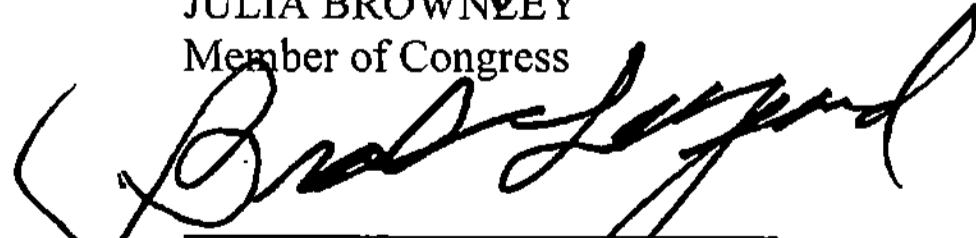

BILLY LONG
Member of Congress

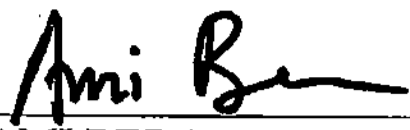

PATRICK E. MURPHY
Member of Congress



JOYCE BEATTY
Member of Congress


CATHY MCMORRIS RODGERS
Member of Congress



JULIA BROWNLEY
Member of Congress

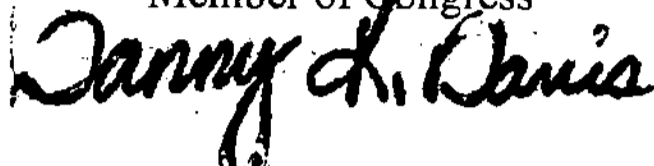

BRAD ASHFORD
Member of Congress

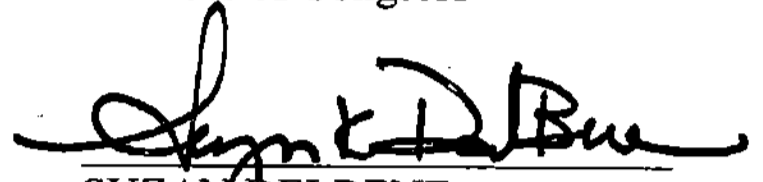

AMI BERA
Member of Congress

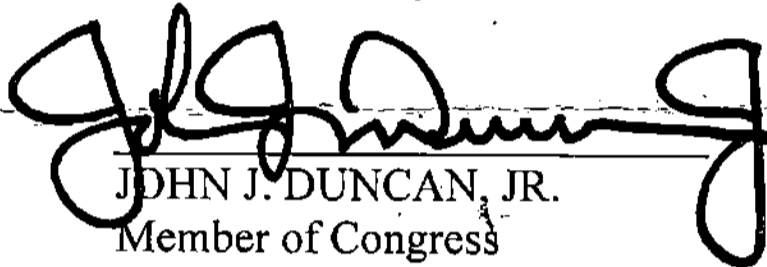

RYAN A. COSTELLO
Member of Congress



RENEE ELLMERS
Member of Congress


BILL PASCRELL, JR.
Member of Congress

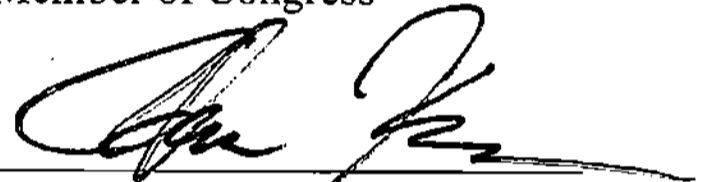

DANNY K. DAVIS
Member of Congress

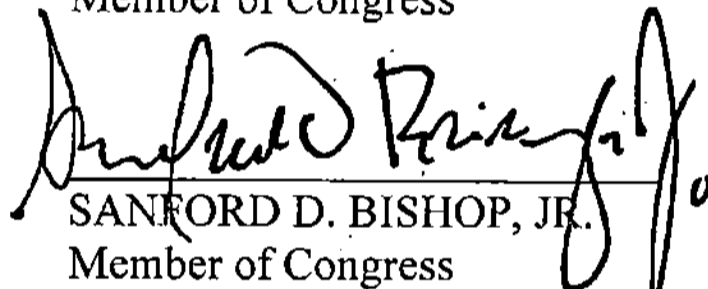

SUZAN DELBENE
Member of Congress

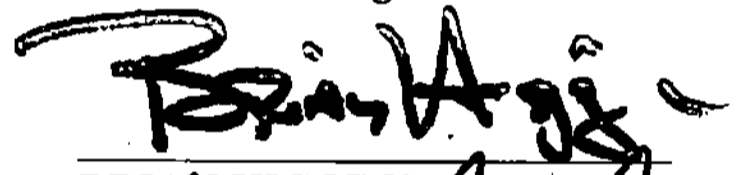

JOHN J. DUNCAN, JR.
Member of Congress



SCOTT PETERS
Member of Congress

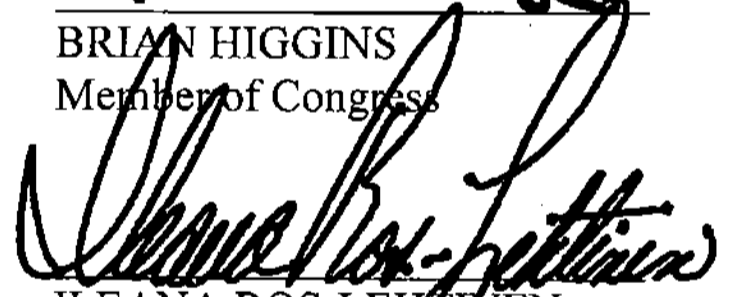

MICHELLE LUJAN GRISHAM
Member of Congress


ADAM KINZINGER
Member of Congress

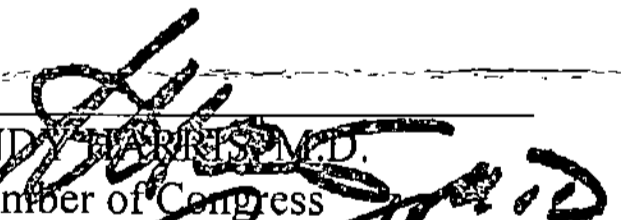

SANFORD D. BISHOP, JR.
Member of Congress


BRIAN HIGGINS
Member of Congress


PATRICK MEEHAN
Member of Congress

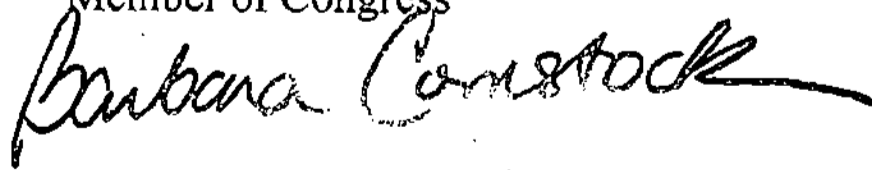

ILEANA ROS-LEHTINEN
Member of Congress

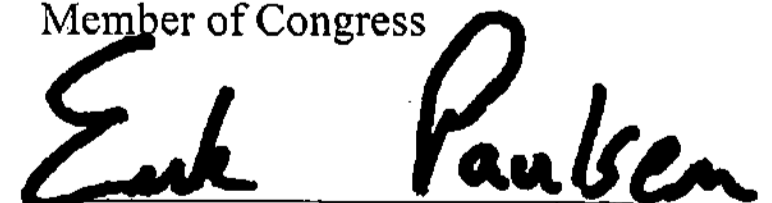

DORIS MATSUI
Member of Congress



ANDY HARRIS, M.D.
Member of Congress

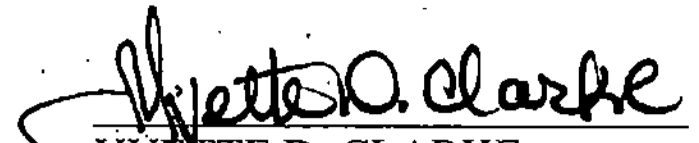

BRIAN BABIN
Member of Congress


RALPH ABRAHAM, M.D.
Member of Congress


BARBARA COMSTOCK
Member of Congress

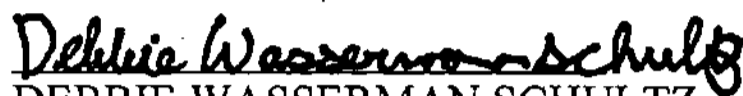

ERIK PAULSEN
Member of Congress

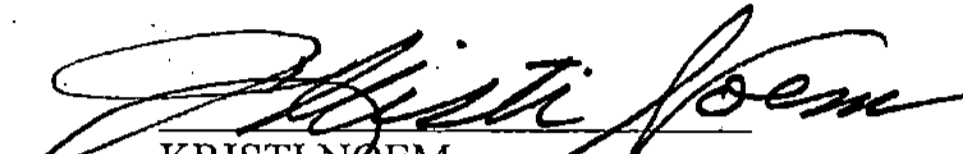

DEVIN NUNES
Member of Congress


YVETTE D. CLARKE
Member of Congress

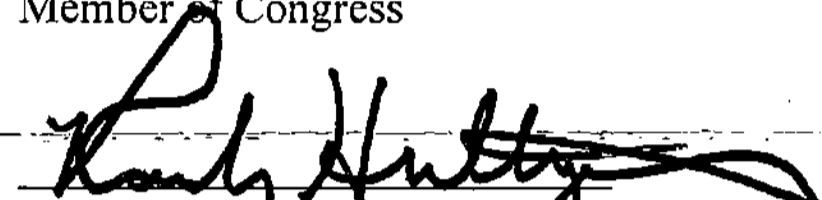

MIKE BISHOP
Member of Congress


CHUCK FLEISCHMANN
Member of Congress

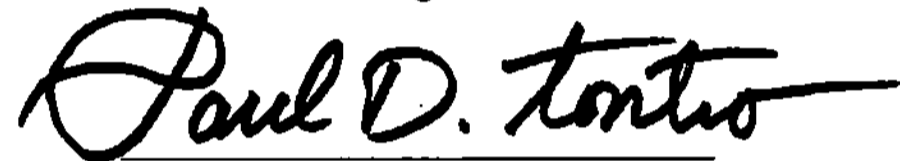

DEBBIE WASSERMAN SCHULTZ
Member of Congress



KRISTI NOEM
Member of Congress

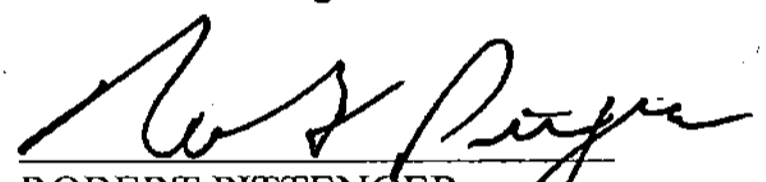

CHELLIE PINGREE
Member of Congress

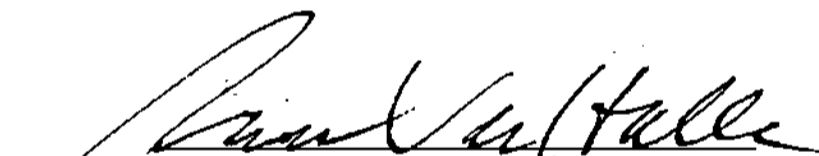

RANDY HULTGREN
Member of Congress



RAUL RUIZ, M.D.
Member of Congress



PAUL TONKO
Member of Congress

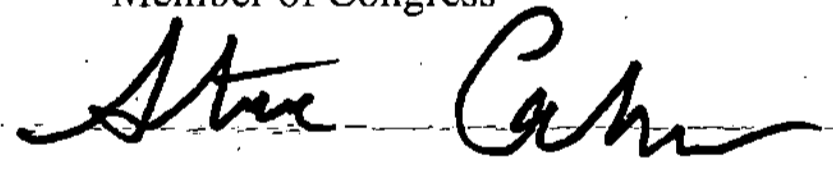

ANDRÉ CARSON
Member of Congress

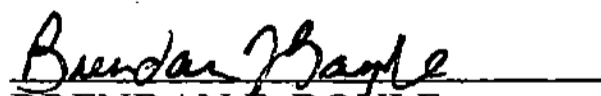

ROBERT PITTENGER
Member of Congress


CHRIS VAN HOLLEN
Member of Congress

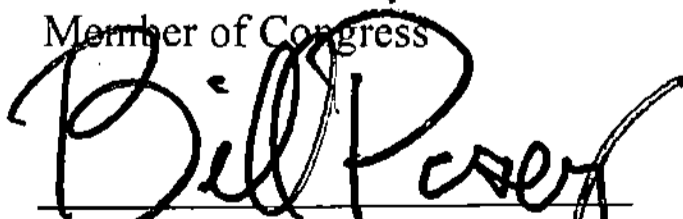

DAVE LOEBSACK
Member of Congress



MARSHA BLACKBURN
Member of Congress


STEVE COHEN
Member of Congress


BRENDAN F. BOYLE
Member of Congress


JOHN B. LARSON
Member of Congress


BILL POSEY
Member of Congress


MICHAEL M. HONDA
Member of Congress



Congress of the United States
House of Representatives
Washington, DC 20515

March 18, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Washington, DC 20201

Dear Ms. Frizzera,

We are writing regarding a recently published proposed rule by the Center for Medicare and Medicaid Services (CMS) that would make changes to the current cytology proficiency testing (PT) requirements (CMS-2252-P). We take great interest in the agency's regulatory interpretation and design of a federal cytology proficiency test and urge you to consider alternative models, such as that provided in the H.R. 1237, Cytology Proficiency Improvement Act. This legislation passed in the House of Representatives last year with strong bipartisan support.

We're concerned that the proposed rule leaves in place the same fundamentally flawed proficiency testing model established in the 1992 regulation. Both the current and proposed tests do not provide a scientifically reliable or valid measure of competency in reading Pap tests. We're equally concerned that CMS has not allowed for the consideration of alternative models in its proposed regulation. The Administration has expressed the need to ensure that regulations are guided by science and effectiveness. This proposed rule does not make that case.

As you know, in 1992, a federal cytology proficiency testing program was established by CMS (then HCFA) as part of implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA). However, it wasn't until 2005, more than a decade after the final regulation was issued, that CMS actually launched the program. In 2006, following considerable pressure from Congress, as well as the laboratory and physician community, CMS and its laboratory advisory committee, the Clinical Laboratory Advisory Committee, (CLIAC) initiated a review of the program and proposed changes. However, the CLIAC was not allowed to consider alternative testing approaches that might differ from the current regulatory model, but still meet CLIA statutory requirements, such as the Cytology Proficiency Improvement Act.

Similarly, the proposed rule does not consider alternative models. This is especially troubling given that the CLIA statute was not specific as to how proficiency should be demonstrated, and by no means mandates or suggests a particular testing regiment. In addition, recently published scientific studies, available to CMS prior to the publication of the proposed rule, concluded that the "test" cannot measure competency unless it's based on close to 100 slides. The CLIAC also heard expert testimony that an individual's ability to read Pap tests does not diminish over time. Although the proposed regulation may be well intended, it does not correct the fact that the testing model to which the changes are proposed remains inherently flawed.

We understand CMS has data regarding cytology proficiency testing results, but has provided no empirical evidence that links "test" results to competency or improved patient outcomes, such as a reduction in false positives or false negatives. Moreover, calling for a 20 slide "test" every two years instead of 10 slides annually will still not produce a meaningful or statistically valid measure of competency. The proposed changes neither take into account the federally mandated responsibilities of the laboratory director, nor recognize that performance data related to the quality and accuracy of reading Pap tests is already documented in the numerous quality measures already established under CLIA. Laboratory directors, as a matter of federal law, are already responsible for utilizing these measures in evaluating the performance of laboratory personnel and must take appropriate corrective action as necessary to ensure quality.

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It is our hope that CMS will allow for periodic reviews of the cytology proficiency testing (PT) requirements in order to continue to use alternative testing requirements and models to ensure patient safety.

Adherence to a proficiency testing model that is scientifically invalid and based on a 16-year old interpretation of the CLIA statute does not advance the fight against cervical cancer. Again, we urge you to consider alternative "testing" models to that proposed in the published rule.

Sincerely,



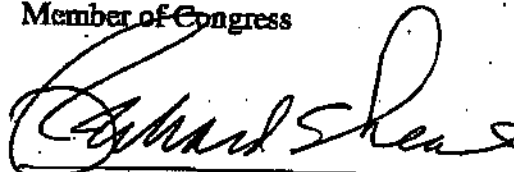
Bart Gordon
Member of Congress



Tom Price, M.D.
Member of Congress



Nathan Deal
Member of Congress



Richard Neal
Member of Congress

cc Charles E. Johnson, Acting Secretary, HHS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 21 2016

Administrator
Washington, DC 20201

The Honorable Tom Price, MD
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the implementation date of our proposed rule to implement Section 216 of the Protecting Access to Medicare Act of 2014. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule implementing this provision went on public display at the Office of the Federal Register on September 25, 2015. We received more than 1,200 comments on the proposed rule prior to the close of the comment period on November 24, 2015. We are currently working to finalize this rule at the soonest possible date.

You urged us to delay the proposed effective date of January 1, 2017, so that laboratories have sufficient time to comply with their reporting obligations once the final rule is issued. We received many comments on the timeline for implementation of this rule similar to yours and discussed these concerns in several meetings with stakeholders in the laboratory community. We are considering our proposed timeline in light of the concerns expressed and will inform you and the public about our decision in the final rule.

We appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515

March 29, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

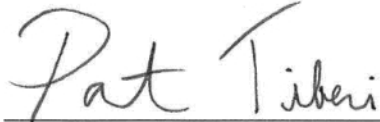
We are writing to express our concerns about the current implementation timeline for Section 216 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93). Given that CMS has yet to issue a final rule to move the Clinical Laboratory Fee Schedule (CLFS) to a market-based payment methodology, we have serious concerns that the process will be improperly rushed in order to meet the existing January 1, 2017 effective date.

Updating the CLFS is a highly complex task with significant implications for all stakeholders, with a reach far beyond the Medicare program. We believe the critical alterations to the CLFS must be accomplished in a deliberate and measured manner, so that laboratories have sufficient time, once the final rule and subregulatory guidance are issued, to comply. **Given the delays in the rulemaking process, the January 1, 2017 effective date for the new CLFS payment methodology is not feasible and should be delayed.**

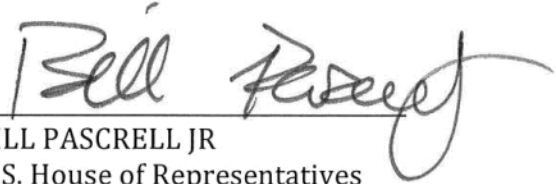
While Section 216 contained an effective date of January 1, 2017 for the new payment system, it included two other deadlines of significance. First, it required that a final rule be issued by June 30, 2015 for publication of a final rule and it required that reporting of prices would begin on January 1, 2016. Obviously, neither of these deadlines has been met. Congress set up this specific set of milestones to ensure that laboratories and CMS would have sufficient time to collect, report, submit and analyze private payor data, and establish new reimbursement rates. We strongly believe this timeframe is necessary to successfully implement market-based reform.

It is imperative that both the Agency and laboratories are afforded the best opportunity to construct this market-based payment system, and implementation should be done in a fair and reasonable manner in the best interests of beneficiaries, clinicians, laboratories, and the Medicare program. We urge CMS to work with Congress, as well as the laboratory and beneficiary communities, on implementation. We look forward to your timely response.


Sincerely,



PAT TIBERI
Chairman
Health Subcommittee
Committee on Ways and Means



BILL PASCRELL JR
U.S. House of Representatives



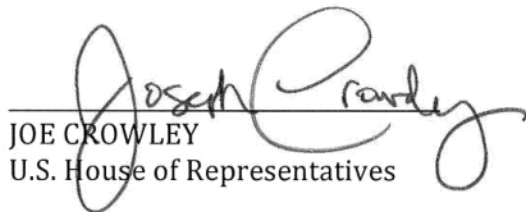
PATRICK MEEHAN
U.S. House of Representatives



CHARLES BOUSTANY JR
U.S. House of Representatives



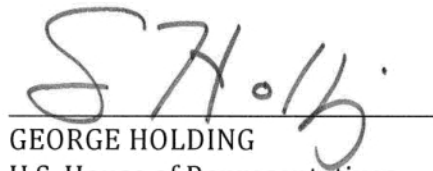
VERN BUCHANAN
U.S. House of Representatives



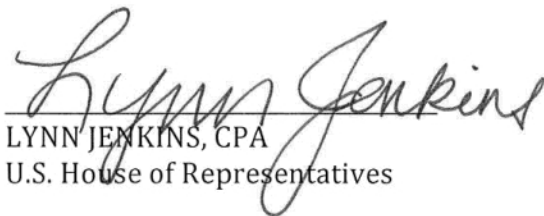
JOE CROWLEY
U.S. House of Representatives



ROBERT J. DOLD
U.S. House of Representatives



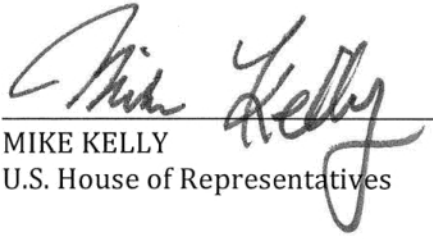
GEORGE HOLDING
U.S. House of Representatives



LYNN JENKINS, CPA
U.S. House of Representatives



SAM JOHNSON
U.S. House of Representatives



MIKE KELLY
U.S. House of Representatives



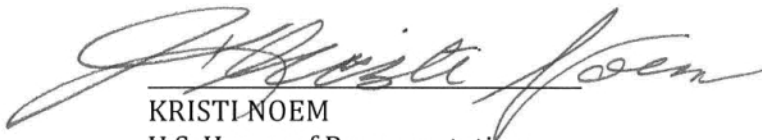
JOHN B. LARSON
U.S. House of Representatives



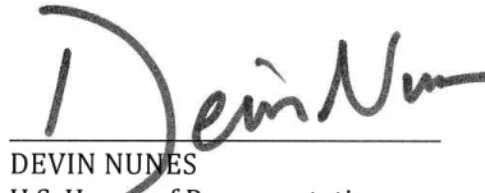
KENNY MARCHANT
U.S. House of Representatives



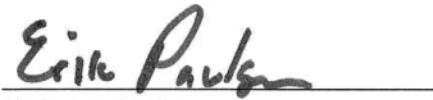
RICHARD NEAL
U.S. House of Representatives



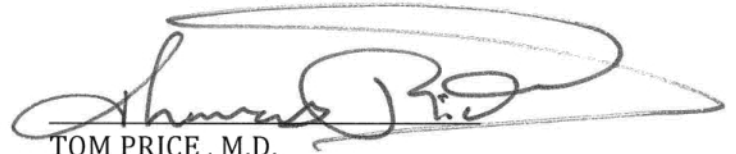
KRISTI NOEM
U.S. House of Representatives



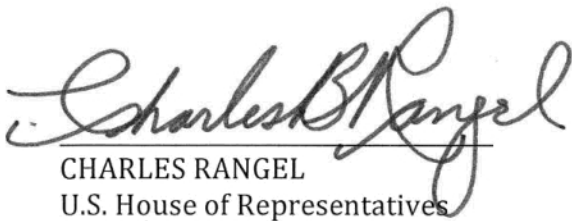
DEVIN NUNES
U.S. House of Representatives



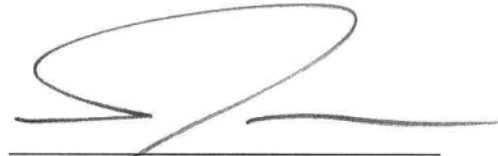
ERIK PAULSEN
U.S. House of Representatives



TOM PRICE, M.D.
U.S. House of Representatives



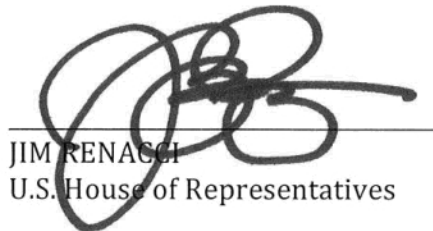
CHARLES RANGEL
U.S. House of Representatives




TOM REED
U.S. House of Representatives

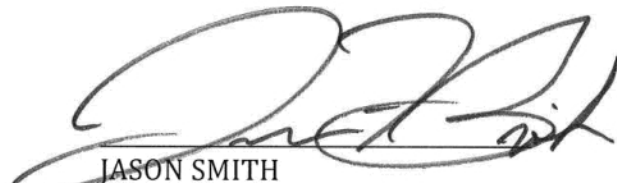


DAVE REICHERT
U.S. House of Representatives

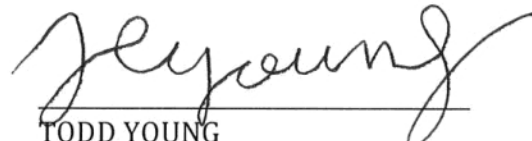



JIM RENACCI
U.S. House of Representatives


LINDA T. SANCHEZ
U.S. House of Representatives


JASON SMITH
U.S. House of Representatives


MIKE THOMPSON
U.S. House of Representatives


TODD YOUNG
U.S. House of Representatives


CHRIS VAN HOLLEN
U.S. House of Representatives



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 10 2014

Administrator
Washington, DC 20201

The Honorable Tom Price ,M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the Advanced Notice of Proposed Rulemaking (CMS-1460-ANPRM) entitled "Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies using Information from Competitive Bidding Programs." The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The advanced notice of proposed rulemaking was issued on February 26, 2014, with a comment period that closed on March 28, 2014. We appreciate your concerns and will carefully consider all comments received during the comment period before making decisions about future proposed rulemaking.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

March 28, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington DC 20201

Dear Administrator Tavenner:

We write to express our concerns with the Centers for Medicare & Medicaid Services (CMS) Advanced Notice of Proposed Rulemaking (CMS-1460-ANPRM) entitled "*Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) using Information from Competitive Bidding Programs*", published on February 26, 2014. We have concerns with the DMEPOS Competitive Bidding Program and believe that prior to any expansion of the program or the application of bid rates to non-competitive bid areas, the structure of the program needs to be further refined.

As you are aware, many Members of Congress have repeatedly weighed in with CMS on issues surrounding the DMEPOS Competitive Bidding Program. Their concerns have stemmed from the lack of transparency, the improper vetting of the financial wherewithal of many firms that have been awarded contracts, and design flaws that were identified by over 240 economists and auction experts, who addressed the lack of binding bids during the bid process. Due to some of these problems, the Health and Human Services Office of Inspector General (OIG) has agreed to further investigate CMS's implementation of the DMEPOS Competitive Bidding Program. Given the OIG's determination, we believe that it would be unwarranted to move in a direction that expands the program to non-competitive bid areas, prior to the findings of the investigation.

While we certainly appreciate CMS's statutory obligation to implement a nation-wide program by 2016, we believe it is more important at this time for CMS to work with Congress in order to address many of these problems. Therefore, we respectfully request that CMS refrain from further action until the finding of the OIG investigation and reports mandated by law have been presented to elected officials and adequate time is provided to review and take action on any findings and recommendations.

We believe that Congress has an appropriate oversight role when it comes to implementing the DMEPOS Competitive Bidding Program. Equally so, we believe that CMS can work with Congress to address these ongoing problems in a manner that will best serve Medicare beneficiaries. We appreciate your consideration and look forward to your timely reply.

Sincerely,



Glenn 'GT' Thompson
Member of Congress



Bruce Braley
Member of Congress

Peter J. Vandy

Michael R. Jones

Lee Perry

Shelley Moore Capito

Anna Smith

Anna Sins

Ralph M. Hall

Paul Brun

Lewis M. Slaughter

Robert J. Wittman

Mr. M. Belani

Richard E. Hall

Rome Lambert

Tom Siskam

J. Whitfield

C. A. Butcher Suppersberger

Tammy Duckworth

Kim Keatt

Pat Tiberi

Carl Potts

How Barletta

[Signature]

Jeff Duncan

Cory Gardner

Bill Roy

Richard Hanna

Steve Rothman

Adam Schik

Kerry L. Benning

Bob Mills

Jeff Miller

[Signature]

Justin

Vicky Hartnell

Chris Cullin

Paul Ryan

Jalynn

Misti Joern

Janet May

Tia Ryan

Mark Adams

Patricia Kelly

Steve Loebach

Quinn Black

Druf P. Jice

Bill Jones

Rodney Davis

William J. Engert

16. Megan Giff

J. John

Bill Johnson

Robt E Jatta

Quid R. Lee

Jackie Walorski

Amil B. Mite

S Holly

Keith Lottgen

Tulsi Gabbard

Ande Grushu

Hank Johnson

Tim Lapp

CPA

[Signature]

Michael E. Caproni

Ti Pij

Gregg Harper

Julie Bauer

Steph Lynd

Thomas Price

Kim R. King

Vern Buchanan

Judy Forbes

Frank Wolz

Brian Agis

John Cahall

Jim Lubert

Brett Guthrie

Marsha Blackburn

Alan Amodeo



TN-04

Elizabeth H. Esty



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUN 27 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter supporting our ongoing efforts to improve the accuracy of payment under the Medicare Physician Fee Schedule (PFS) through the potentially misvalued codes initiative. You request that we modify our current process to allow public comment on revised payment values before being paid at those revised rates. We have heard this comment from many stakeholders and appreciate hearing from you on this issue.

As you may be aware, the PFS relies on standard code sets adopted under the Health Insurance Portability and Accountability Act of 1996 – principally, the Current Procedural Terminology (CPT) coding system maintained by the American Medical Association (AMA). CPT's coding cycle occurs concurrently with our PFS calendar year rulemaking cycle. New and revised CPT codes are not in the public domain at the time of our proposed rule; coding changes frequently are made in conjunction with our potentially misvalued codes initiative.

Another key component in the PFS is the valuation recommendations we receive from the AMA Specialty Society Relative Value Update Committee (AMA RUC). The Centers for Medicare & Medicaid Services (CMS) typically does not receive AMA RUC recommendations for new, revised, and potentially misvalued CPT codes in time to consider them for the proposed rule and therefore establishes interim final values in each year's final rule upon which we make payment as we also review and respond to public comments.

The CMS has been sensitive to the concern raised in your letter and has been considering whether our processes can be changed so that all proposed revisions to the values for misvalued codes go through notice and comment rulemaking before making payment on those values. The AMA has also been considering changes to the CPT and RUC processes to accommodate these concerns. In a recent letter to CMS, the AMA proposed scheduling changes to the CPT and RUC processes that are designed to provide CMS with information that would allow us to propose changes to misvalued code values in the annual PFS proposed rule. We are currently reviewing the AMA's proposed changes and plan to discuss the issue further with them to make any refinements or changes that would be necessary to achieve the goals outlined in your letter.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name being the most prominent.

Marilyn Tavenner

625831

Treat as an original

Congress of the United States
Washington, DC 20515

Cmm
090420084021

Cis # 625831

DUE Date -7-26-07

July 13, 2007

2007 JUL 19 AM 11:23

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C5-11-24
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

We are writing to express our concerns regarding patient access to critical medical technologies and supplies under the new competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) which is required to be implemented by the Centers for Medicare and Medicaid Services (CMS) under section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Access to quality DME and related services can often mean the difference between a patient being able to remain in their own home or being forced into a nursing home or hospital. DME enables providers to give essential care to many of the frailest and sickest Medicare patients, including oxygen therapy for patients with abnormal blood oxygen levels, respiratory-assist devices for patients who are at risk of acute respiratory distress, and enteral nutrition for nutritionally compromised patients.

Although Congress instructed CMS to begin implementing the competitive bidding program in 2007, we strongly believe that due to its direct impact on daily patient care, it must be carefully implemented with significant attention to details, especially the impact on patients. Transitioning to competitive bidding is a major and highly complex undertaking. A large number of issues must be addressed to assure that access and quality of care will not be jeopardized. We strongly urge CMS to take the following steps to address these issues before the bidding process closes and implementation is finalized:

1. **Product Categories and Codes** Product codes used by CMS are too broad and inconsistent to adequately describe products with diverse and broad ranges of quality, functionality, technology, and clinical utility. Beneficiaries may not have access to a full range of products if the accepted bidding amount does not reflect the varying

1. costs of the range of products. Some categories or codes that comprise those categories, such as support services, complex rehabilitation services, enteral nutrition, and negative pressure wound therapy, are so broad or undifferentiated as to raise important quality issues. There is also confusion over how new technologies and products will be categorized once prices are established. We are concerned that patient access to new products may be compromised using these broad and inconsistent codes. **We recommend that CMS accept and give serious consideration to stakeholder input on refinement of proposed product category subdivisions prior to bidding.**
2. **Compressed Implementation Timeline and Small Suppliers.** The Final Rule came out April 10, 2007 and the bidding process closes on July 13, 2007. Winning suppliers will be announced in December 2007 with payments going into effect in the initial 10 competitive bidding areas (CBAs) in April 2008. The Final Rule is highly complex; interested suppliers need a portion of the bidding period to analyze it and gather information to submit informed bids. The 60-day bidding process does not provide sufficient time for suppliers to learn about the important details and obtain answers to key questions relevant to the preparation of their bids, or allow small suppliers to form the provider networks that are needed for them to participate in the program. Currently, CMS is providing more details regarding the program, but this occurring while the clock is ticking on the 60-day window to bid.

Small suppliers that wish to participate in bidding networks must develop new business organizations to maintain Medicare participation, implement untried computer systems, and address a large number of unresolved policy issues. Participating small suppliers would also face steep expenses from the necessary market assessment and compliance procedures that they would have to bear to ensure that their participation does not subject them to antitrust action and other legal risks. Guidance is needed from CMS or the Department of Justice on how suppliers can avoid violating antitrust laws while disclosing information necessary to determine how to form supplier networks. The formation of these networks would require disclosure and agreement between small suppliers on prices and on which competitive opportunities to pursue.

We recommend that CMS realign the bidding timeline to begin the process after all bidder conferences have occurred. We also urge that sufficient time be provided for as many suppliers as possible to begin and conclude the accreditation process.

3. **Distinction Between Long-Term Care Facilities, Home Health Agencies, and DME Companies.** Different skills are required for long-term care facilities, home health agencies, and DME companies. While long-term care facilities provide medical personnel to administer the enteral products, the Part B provider is required to review medical charts of the beneficiaries to determine actual usage for claims submitted. DME companies are not equipped to service the needs of skilled nursing facilities, which may serve 10-20 enteral patients. Suppliers not currently serving the

home care market will have to make significant changes in the way they operate and serve their customers, including carrying products they are currently unfamiliar with and do not have existing relationships with manufacturers or suppliers. Patient care may be at risk as suppliers learn and adapt to new markets.

4. **Median Price Methodology.** Under the median price methodology, half of the "winning" bidders will be paid for DMEPOS at a rate below what they bid. The Final Rule leaves unanswered the question of whether DMEPOS suppliers would be able to withdraw from offering to supply an item if it is below their submitted bid price. We are concerned that 'winning' suppliers may choose not to participate or would be unable to supply quality products and services if they are forced to provide products at a price below their submitted bid price.

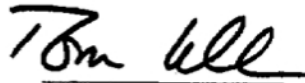
5. **Impact on Patients and Medicare Expenditures.** CMS has not yet presented plans to evaluate the impact of competitive bidding on clinical outcomes, beneficiaries, or Medicare expenditures in other care settings. This is concerning because the program will be implemented in a condensed time frame. **We recommend that specific steps be delineated by CMS on how it intends to provide ongoing assessment of the program. This would include clinical outcomes for patients, including those receiving negative pressure wound therapy, support surfaces and blood glucose self-monitoring for patients with diabetes.**

Thank you for your attention to these important issues. We look forward to working with you to address these outstanding concerns before implementation begins.

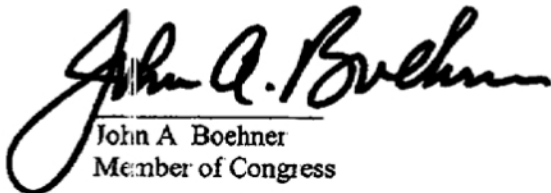
Sincerely,



Sam Johnson
Member of Congress



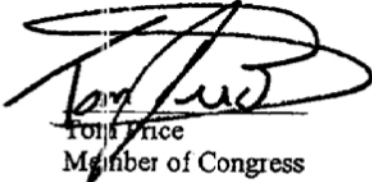
Tom Allen
Member of Congress



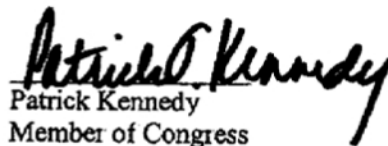
John A. Boehner
Member of Congress



Chet Edwards
Member of Congress



Tom Price
Member of Congress



Patrick Kennedy
Member of Congress

Jason Altmire
Jason Altmire
Member of Congress

Sam Farr
Sam Farr
Member of Congress

Paul E. Gillmor
Paul E. Gillmor
Member of Congress

Steve Kagen
Steve Kagen
Member of Congress

Michael H. Michaud
Michael H. Michaud
Member of Congress

John W. Olver
John W. Olver
Member of Congress

Tim Ryan
Tim Ryan
Member of Congress

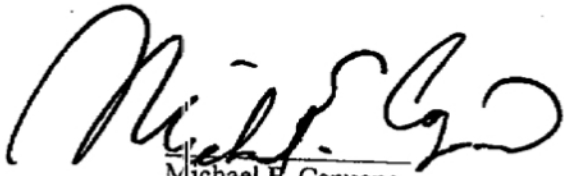
Pete Sessions
Pete Sessions
Member of Congress

Christopher Shays
Christopher Shays
Member of Congress

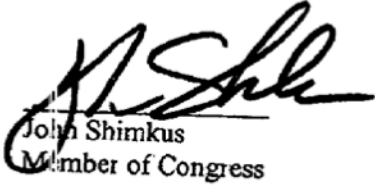
Carol Shea-Porter
Carol Shea-Porter
Member of Congress

Betty Sutton
Betty Sutton
Member of Congress

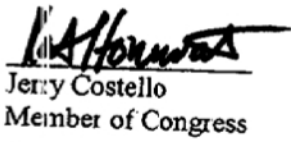
Peter Welch
Peter Welch
Member of Congress



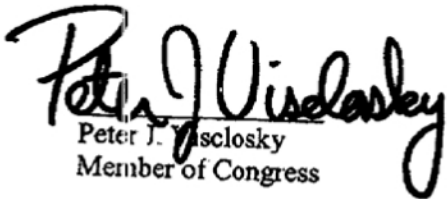
Michael E. Capuano
Member of Congress




John Shimkus
Member of Congress



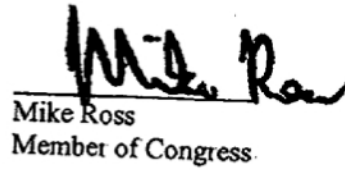
Jerry Costello
Member of Congress



Peter J. Visclosky
Member of Congress



James R. Langevin
Member of Congress



Mike Ross
Member of Congress



Michael F. Doyle
Member of Congress

Dennis J. Kucinich

Dennis J. Kucinich
Member of Congress

Jarice D. Schakowsky

Jarice D. Schakowsky
Member of Congress

Ciro D. Rodriguez

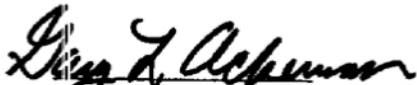
Ciro D. Rodriguez
Member of Congress

Emanuel Cleaver

Emanuel Cleaver
Member of Congress

Jerold Nadler

Jerold Nadler
Member of Congress



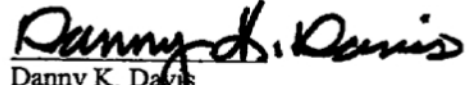
Gary L. Ackerman
Member of Congress



Tammy Baldwin
Member of Congress



Rick Boucher
Member of Congress



Danny K. Davis
Member of Congress



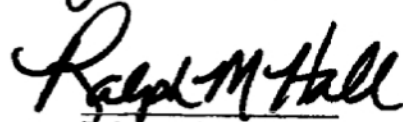
William D. Delahunt
Member of Congress



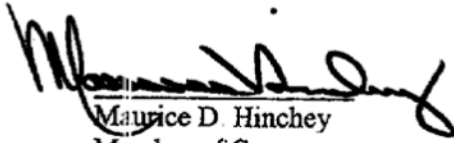
Jo Ann Emerson
Member of Congress



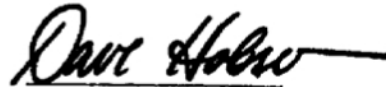
Blaine Frank
Member of Congress



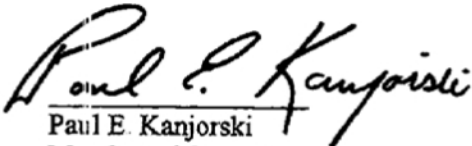
Ralph M. Hall
Member of Congress



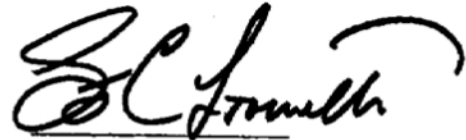
Maurice D. Hinchey
Member of Congress



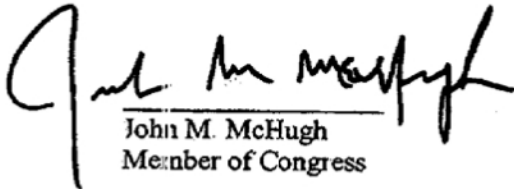
David L. Hobson
Member of Congress



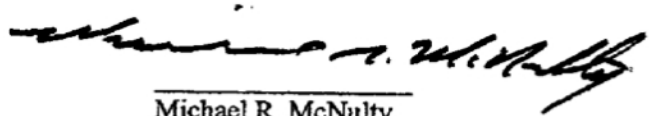
Paul E. Kanjorski
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Steven C. LaTourette
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John M. McHugh
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Michael R. McNulty
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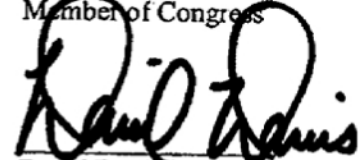

Timothy H. Bishop
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Marsha Blackburn
Member of Congress



Ginny Brown-Waite
Member of Congress

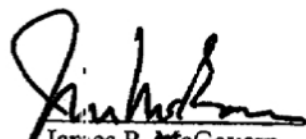

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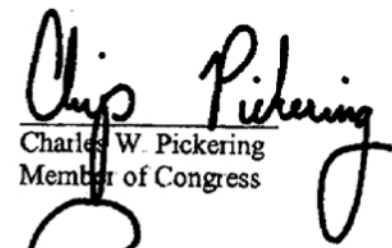

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Member of Congress



David Davis
Member of Congress



Charles A. Gonzalez
Member of Congress

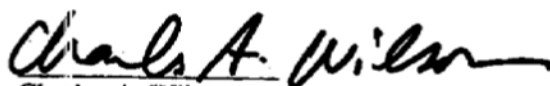

Brian Higgins
Member of Congress

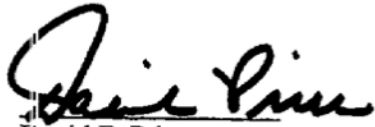

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Charles W. Pickering
Member of Congress


Jan Schmidt
Member of Congress


Patrick J. Tiberi
Member of Congress

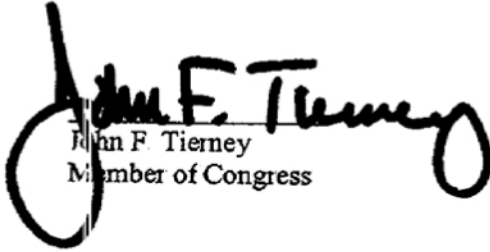

Charles A. Wilson
Member of Congress



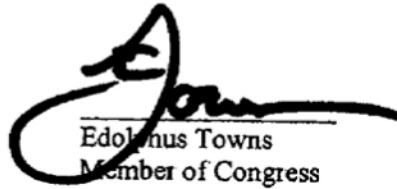
David E. Price
Member of Congress



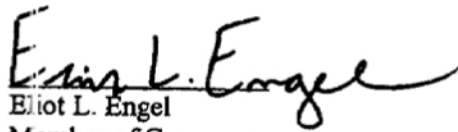
Collin C. Peterson
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John F. Tierney
Member of Congress



Edonus Towns
Member of Congress



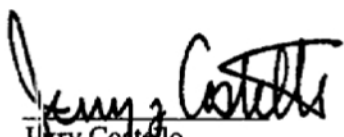
Elliot L. Engel
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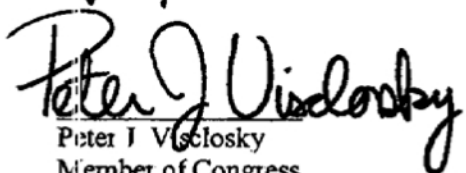
Michael E. Capuano
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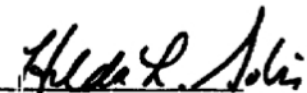
John Shimkus
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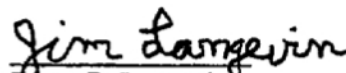
Harry Costello
Member of Congress



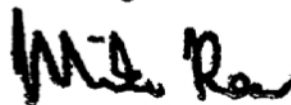
Peter J. Visclosky
Member of Congress



Hilda L. Solis
Member of Congress



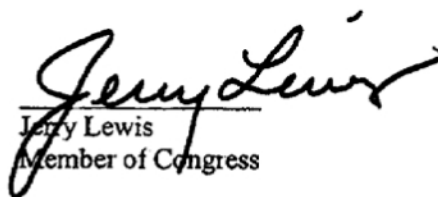
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Member of Congress



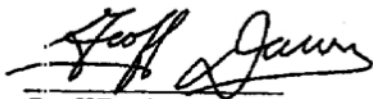
Mike Ross
Member of Congress



Michael F. Doyle
Member of Congress



Jerry Lewis
Member of Congress

A handwritten signature in black ink, appearing to read "Geoff Davis". The signature is written in a cursive style with a horizontal line underneath it.

Geoff Davis
Member of Congress



SEP 20 2016

Administrator
Washington, DC 20201

The Honorable Tom Price, MD
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter detailing your feedback and concerns regarding the public reporting of the Overall Hospital Quality Star Ratings on *Hospital Compare*. The Centers for Medicare & Medicaid Services (CMS) has a longstanding commitment to improving healthcare outcomes. One of the ways CMS works to achieve this goal is by working with stakeholders to improve performance on individual quality measures. Over the past decade, CMS has published information about the quality of care across the five different health care settings that most families encounter. The Overall Hospital Quality Star Rating represents a summary of hospital performance based on 64 measures across seven quality aspects currently available on *Hospital Compare*, the vast majority of which have been through review and endorsement by the National Quality Forum (NQF).

The Overall Hospital Quality Star Ratings were initially scheduled to be released on April 21, 2016. Due to stakeholder questions, including those raised in your letter, CMS chose to delay public reporting of the Star Ratings, and, in the interim, worked with hospitals and other stakeholders to provide more information on the methodology for calculation of the Star Ratings. During this time, the CMS Star Ratings team conducted significant outreach and a transparent release of information to discuss the concerns that some hospitals and stakeholders had and to answer their questions. As part of this committal to transparency, CMS also released the distributions of the Overall Hospital Quality Star Rating based on hospital characteristics, which can be found at:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228775183434>. CMS also received letters of support from several consumer advocacy organizations encouraging CMS to release the Star Ratings at the earliest possible time. After we listened to concerns and provided this additional transparency, CMS released the Overall Hospital Quality Star Ratings and supporting data on July 27, 2016.

The goal of the Overall Hospital Quality Star Rating is to summarize the quality of hospital performance. These Star Ratings should be used as a supplement to the existing quality measures that are publicly reported. The Overall Hospital Quality Star Ratings are based on performance on measures of routine care across seven different areas: (1) death rates, (2) safety, (3) readmission to the hospital, (4) patient experiences, (5) effectiveness of care, (6) timeliness of care, and (7) efficient use of medical imaging. These Star Ratings are completely consistent with the information from quality measures already reported on *Hospital Compare* and are designed to help patients and families learn about the quality of services offered by hospitals, compare facilities side by side, and prepare questions for their healthcare provider before a hospital visit. These ratings are intended to be one of many resources available when choosing a hospital.

The methodology used to calculate the Star Rating is a scientifically rigorous way to summarize the quality information available on *Hospital Compare*. CMS understands the concern that other rating reports available online may show different results. Prior to developing this methodology, CMS reviewed several methodologies that would be appropriate for comparing hospitals with the varying numbers and types of measures available on *Hospital Compare*. CMS also reviewed numerous other ratings systems and determined that each one included different data sources, including proprietary information, and carried distinct objectives that would not be consistent with the intent of the Overall Hospital Quality Star Rating and the needs of beneficiaries. Other methodologies reviewed for this work included the methodology used in the Hospital Consumer Assessment of Healthcare Providers and Systems' patient experience Summary Star Ratings, Nursing Home Compare Star Ratings, Medicare Plan Finder methodology, and several non-government methodologies such as Leapfrog Safety Score, Consumer Reports, and Healthgrades.

The CMS has made substantial efforts to engage with the public, including hospitals, on the Overall Hospital Quality Star Rating project. CMS reached out to various stakeholder groups and hospitals asking for nominations to a Technical Expert Panel (TEP). The members of the TEP ultimately included experts in measure development and Star Ratings, hospital representatives, hospital association members, consumer advocates, and the general public to provide the patient perspective. A total of three TEP meetings were held. The first TEP meeting focused on the measure selection criteria for inclusion in the Star Rating calculation, while the next two focused on the statistical and policy details in developing the methodology. CMS also held two opportunities for public input and received feedback on the methodology and measure selection criteria from stakeholders. CMS publicly posted the methodology reports on the [qualitynet.org](http://www.qualitynet.org) website at:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FOnetTier2&cid=1228775183434>. Additionally, CMS held two national provider calls to further review and explain the methodology for calculating Overall Hospital Quality Star Ratings in detail, allowing participants to ask questions. Transcripts of both calls, including the questions and answers, are publicly available at: http://www.qualityreportingcenter.com/wp-content/uploads/2016/05/IQR_20160512_Presentation-Transcript_vTR_FINAL.508.pdf.

In response to stakeholder concerns surrounding data availability, CMS provided the full Statistical Analytical Software code, required user guides and input file, which contain all of the national data at the time the Star Ratings were posted, all of which are available on the [qualitynet.org](http://www.qualitynet.org) website at:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FOnetTier2&cid=1228775183434>. This information should allow hospitals to recreate their scores and calculate their Overall Hospital Quality Star Rating independently.

Transparency and input from numerous stakeholders were guiding principles in the development of the Overall Hospital Quality Star Ratings. CMS intends to continue this engagement with stakeholders through ongoing consultation of the TEP, public input, *Hospital Compare* support

calls and materials, national provider calls, an existing email inbox, and active solicitation of feedback to inform future improvements to the methodology.

In order to specifically address the issue of risk adjustment for sociodemographic status, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program. CMS will closely examine findings of the ASPE reports and related secretarial recommendations and consider how they apply to our quality programs at such time as they are available. Also, the NQF is currently undertaking a 2-year trial period in which new measures and measures undergoing maintenance review will be assessed to determine if risk-adjusting for sociodemographic factors is appropriate. At the conclusion of the trial, the NQF will issue recommendations on future permanent inclusion of sociodemographic factors. Several measures developed by CMS have been brought to the NQF since the beginning of the trial. CMS, in compliance with NQF's guidance, has tested sociodemographic factors in the measures' risk models and made recommendations about whether or not to include these factors in the endorsed measure. CMS intends to continue engaging in the NQF process as considerations are made regarding the appropriateness of adjusting for sociodemographic factors in the outcome measures. In the meantime, our analysis shows that the adjustments that are already made account for the illness burden of the patient seen at a hospital and account for many of the concerns that safety net hospitals have without setting a second standard for people with socioeconomic status factors.

The CMS believes that publicly available data drives improvement, and that this will be a step forward in our commitment to transparency. CMS is committed to continuing to work closely with hospitals and other stakeholders to enhance the Overall Hospital Quality Star Rating based on continued feedback and experience. CMS would like to reiterate our appreciation for your continued and thoughtful engagement in CMS's quality measurement work. CMS firmly believes that active stakeholder participation by hospitals, patients, consumers and other stakeholders has been, and will continue to be, critical to the ongoing implementation and evolution of the Overall Hospital Quality Star Ratings. Please contact Megan O'Reilly, Director of the Office of Legislation, at 202-690-5960 if you have additional questions or if the Star Ratings team can be of further assistance to you regarding the Overall Hospital Quality Star Ratings. I will also provide this response to the co-signers of your letter.

Sincerely,



Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

April 18, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

We are writing to express some concerns with the hospital star rating system that CMS plans to publicly release in April 2016. While we strongly support public reporting of provider quality data, we urge you to ensure that this data adequately accounts for hospital patient mixes that include higher proportions of patients with multiple complex chronic health conditions and lower socioeconomic status. We also request that you provide hospitals with more details on the methodology used to determine their star ratings.

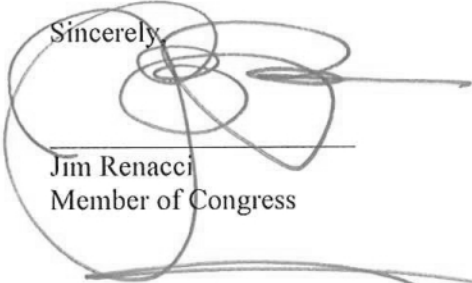
We want to make sure that the star rating system is not misleading to consumers because of flaws in the measures that underpin the ratings. As you know, many prominent hospitals that are in the top echelon of other quality rating reports, and handle the most complex procedures and patients, will receive one or two stars (out of a possible five), indicating that they have the poorest quality in comparison to other hospitals.

We are concerned that the hospital star ratings, in their current form, may be unfairly masking quality or, possibly, over-weighting of patient experience measures and will therefore not help consumers make well-informed decisions about which hospitals to use. A number of the quality measures that underpin the ratings unfairly impact teaching hospitals that treat low socioeconomic status patients, more complex patients, and perform a greater number of complicated surgeries. MedPAC, the National Quality Forum, and other researchers have underscored the importance of appropriately adjusting for socioeconomic status and patient complexity; and CMS has recognized the need for this adjustment in the Medicare Advantage and Medicare Part D programs. We also encourage CMS to incorporate the Office of the Assistant Secretary for Planning and Evaluation's forthcoming findings on the impact of socioeconomic status on quality measures into future star ratings.

Additionally, we are concerned that CMS has provided insufficient details regarding the methodology used to determine these star ratings and has not provided hospitals with the data used to derive the ratings. We have heard from hospitals in our districts that they do not have the necessary data to replicate or evaluate CMS's work to ensure that the methodology is accurate or fair. We believe that additional time is necessary for hospitals and stakeholders to thoroughly review the data and understand the impact of the current methodology to ensure the validity and accuracy of the information before it is publicly released. We respectfully request that you delay release of the star ratings to provide the necessary time to more closely examine the star rating methodology, analyze its impact on different types of hospitals, and provide more transparent information regarding the calculation of the ratings to determine accuracy.

We want to work together to ensure that hospitals are not penalized for treating the most vulnerable or complex patients in the star ratings system, the Hospital Readmissions Reduction Program, or any other quality program. We urge CMS to work with Congress and the hospital community to resolve these concerns. Thank you for your consideration of this request. We look forward to your response.

Sincerely,



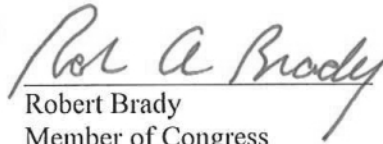
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Member of Congress



Bill Pascrell
Member of Congress



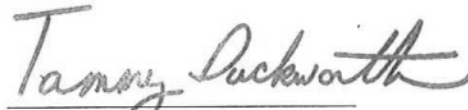
Tom Price, M.D.
Member of Congress



Robert Brady
Member of Congress



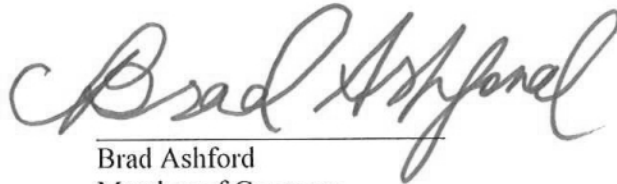
Donald M. Payne, Jr.
Member of Congress



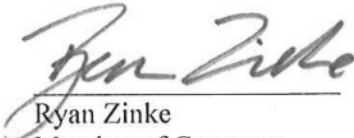
Tammy Duckworth
Member of Congress



Jeff Duncan
Member of Congress



Brad Ashford
Member of Congress



Ryan Zinke
Member of Congress



Justin Amash
Member of Congress



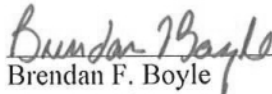
Lou Barletta
Member of Congress



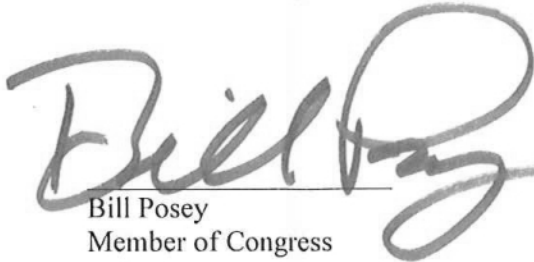
Debbie Dingell
Member of Congress



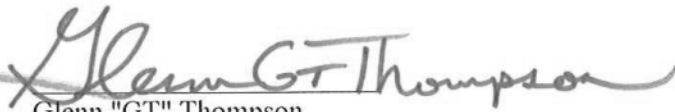
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Brendan F. Boyle
Member of Congress



Bill Posey
Member of Congress



Glenn "GT" Thompson
Member of Congress



Robert Hurt
Member of Congress



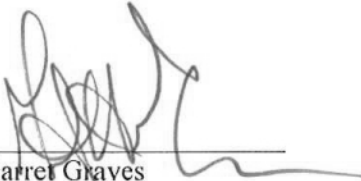
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Member of Congress



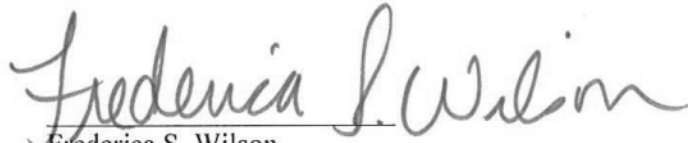
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Member of Congress



Ann McLane Kuster
Member of Congress



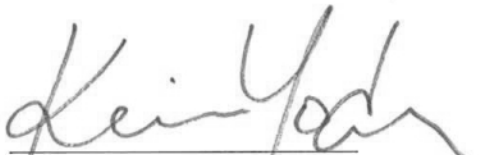
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Member of Congress



Frederica S. Wilson
Member of Congress



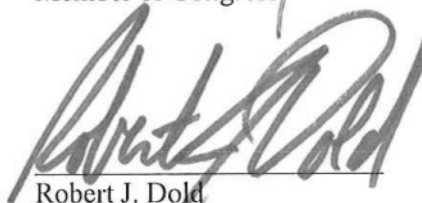
Michelle Lujan Grisham
Member of Congress



Kevin Yoder
Member of Congress



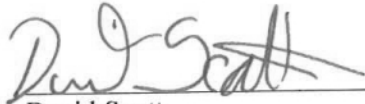
Scott Tipton
Member of Congress



Robert J. Dold
Member of Congress



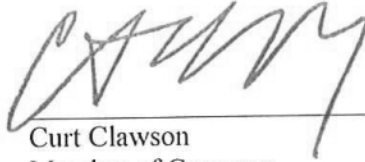
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Member of Congress



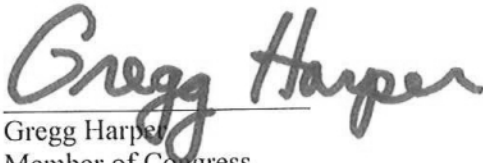
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Member of Congress



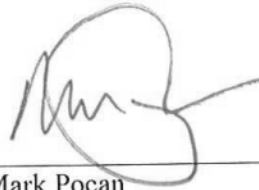
Dan Kildee
Member of Congress



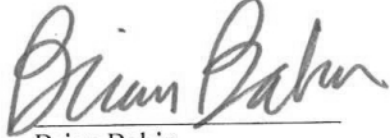
Curt Clawson
Member of Congress



Gregg Harper
Member of Congress



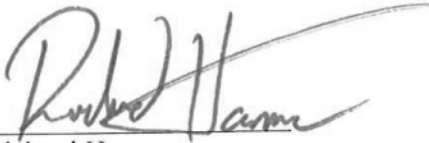
Mark Pocan
Member of Congress



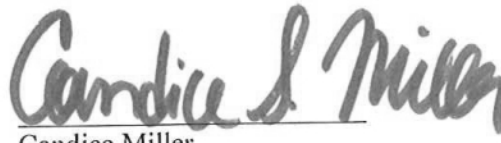
Brian Babin
Member of Congress



Suzan DelBene
Member of Congress



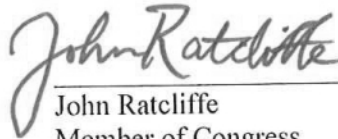
Richard Hanna
Member of Congress



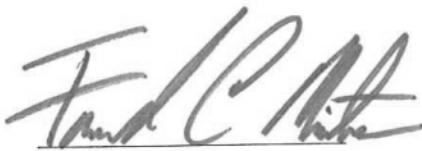
Candice Miller
Member of Congress



Mike Rogers
Member of Congress



John Ratcliffe
Member of Congress



Frank C. Guinta
Member of Congress



Bob Gibbs
Member of Congress

Dave Brat Steven Palazzo

Dave Brat
Member of Congress

Steven Palazzo
Member of Congress

Mark V. Amodei

Mark Amodei
Member of Congress

Peter King

Peter King
Member of Congress

Richard E. Neal

Richard E. Neal
Member of Congress

John Lewis

John Lewis
Member of Congress

Phil Roe

Phil Roe
Member of Congress

Tom Marino

Tom Marino
Member of Congress

David B. McKinley, P.E.

David B. McKinley, P.E.
Member of Congress

Ted Lieu

Ted Lieu
Member of Congress

Ken Buck

Ken Buck
Member of Congress

Ralph Abraham, M.D.

Ralph Abraham, M.D.
Member of Congress

Scott Rigell

Scott Rigell
Member of Congress

Jackie Walorski

Jackie Walorski
Member of Congress

David Rouzer
David Rouzer
Member of Congress

Denny Heck
Denny Heck
Member of Congress

Bruce Poliquin
Bruce Poliquin
Member of Congress

Ryan Costello
Ryan Costello
Member of Congress

Mike Bishop
Mike Bishop
Member of Congress

Richard Hudson
Richard Hudson
Member of Congress

Donald S. Beyer Jr.
Donald S. Beyer Jr.
Member of Congress

Earl L. "Buddy" Carter
Earl L. "Buddy" Carter
Member of Congress

Patrick Meehan
Patrick Meehan
Member of Congress

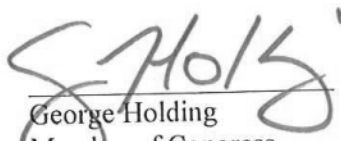
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Ann Wagner
Member of Congress

Mike Pompeo
Mike Pompeo
Member of Congress

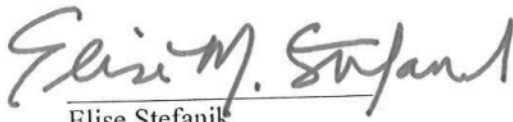
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James P. McGovern
Member of Congress


Tom Emmer
Tom Emmer
Member of Congress


Tom MacArthur
Tom MacArthur
Member of Congress

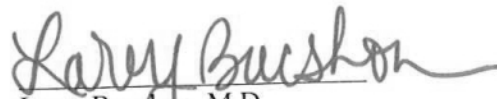

George Holding
Member of Congress

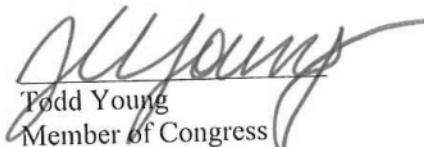

Luke Messer
Member of Congress

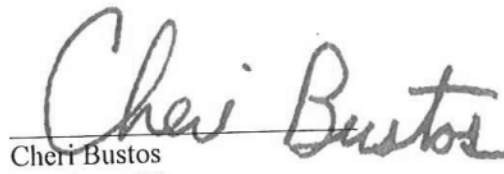

Elise Stefanik
Member of Congress

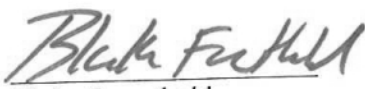

Dan Benishek M.D.
Member of Congress



David Young
Member of Congress

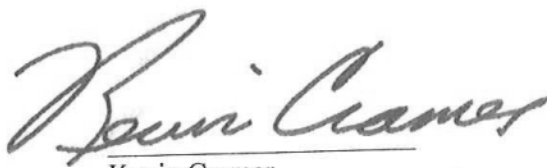

Larry Bucshon, M.D.
Member of Congress

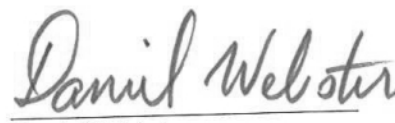

Todd Young
Member of Congress

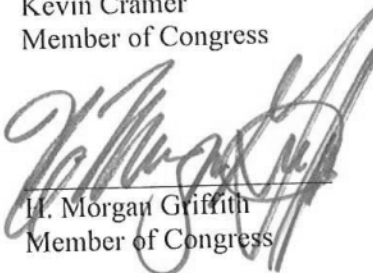

Cheri Bustos
Member of Congress

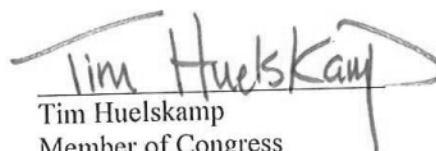

Blake Farenthold
Member of Congress

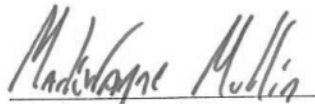

Martha McSally
Member of Congress

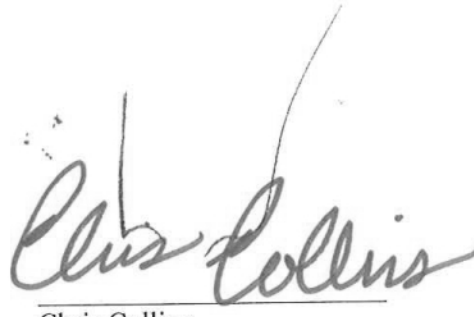

Kevin Cramer
Member of Congress


Daniel Webster
Member of Congress



H. Morgan Griffith
Member of Congress



Tim Huelskamp
Member of Congress



Markwayne Mullin
Member of Congress

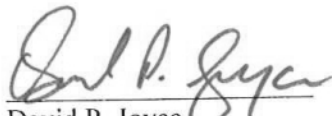

Chris Collins
Member of Congress

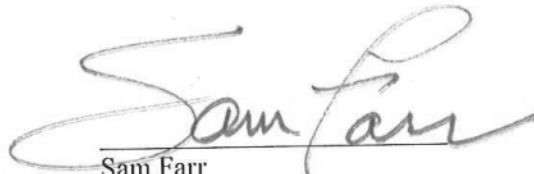

Jason Smith
Member of Congress


Steve Womack
Member of Congress

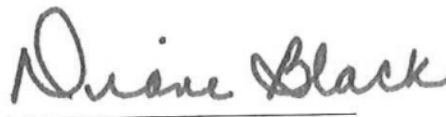

Scott Peters
Member of Congress

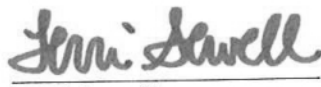

John Katko
Member of Congress

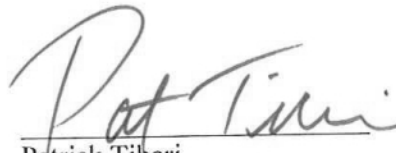

David P. Joyce
Member of Congress

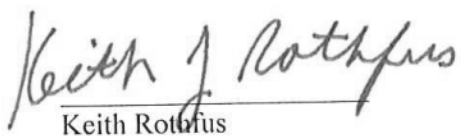

Sam Farr
Member of Congress

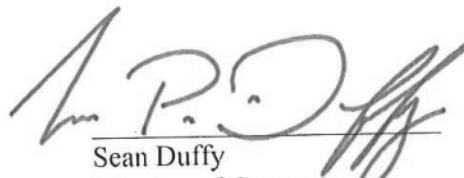

Dave Reichert
Member of Congress

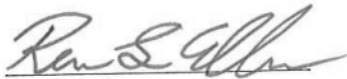

Diane Black
Member of Congress


Terri Sewell
Member of Congress

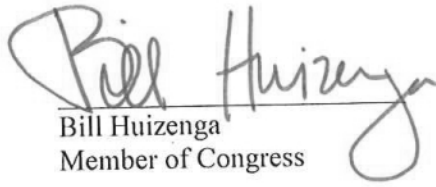

Patrick Tiberi
Member of Congress


Keith Rothfus
Member of Congress


Sean Duffy
Member of Congress



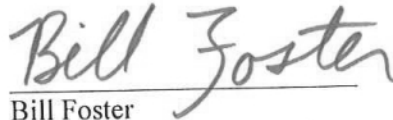
Renee Ellmers
Member of Congress



Bill Huizenga
Member of Congress



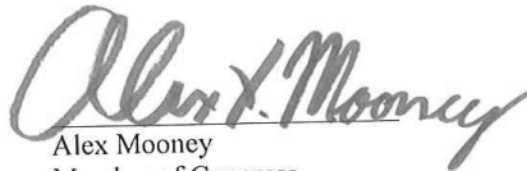
Adam Kinzinger
Member of Congress



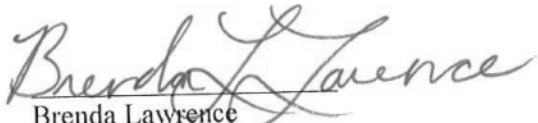
Bill Foster
Member of Congress



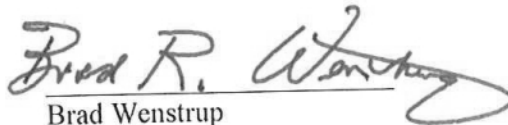
French Hill
Member of Congress



Alex Mooney
Member of Congress



Brenda Lawrence
Member of Congress



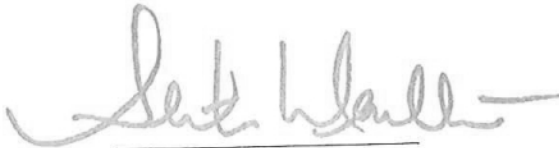
Brad Wenstrup
Member of Congress



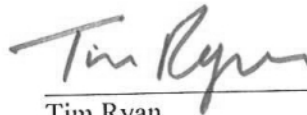
Beto O'Rourke
Member of Congress



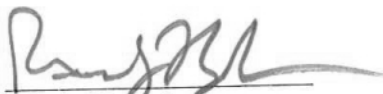
Trey Gowdy
Member of Congress



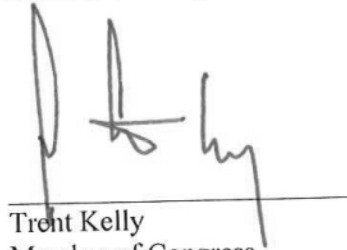
Seth Moulton
Member of Congress



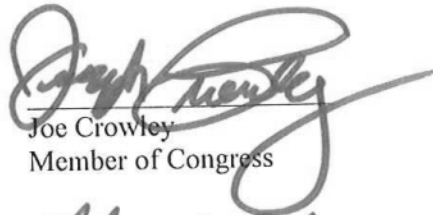
Tim Ryan
Member of Congress



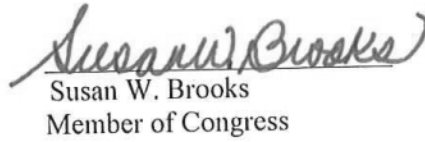
Randy Neugebauer
Member of Congress



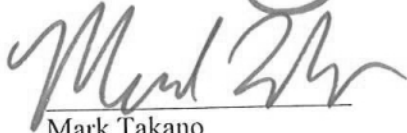
Trent Kelly
Member of Congress



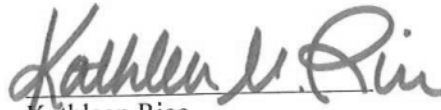
Joe Crowley
Member of Congress



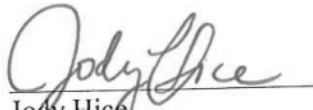
Susan W. Brooks
Member of Congress



Mark Takano
Member of Congress



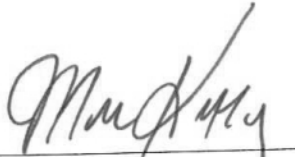
Kathleen Rice
Member of Congress



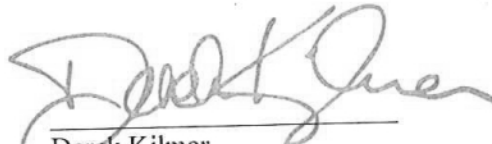
Jody Hice
Member of Congress



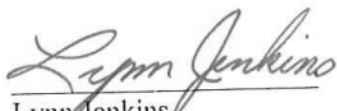
Lee Zeldin
Member of Congress



Mike Kelly
Member of Congress



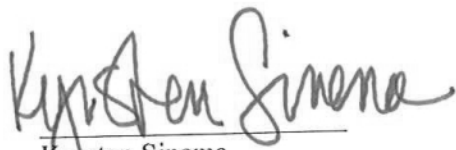
Derek Kilmer
Member of Congress



Lynn Jenkins
Member of Congress



Sean Patrick Maloney
Member of Congress




Kyrsten Sinema
Member of Congress



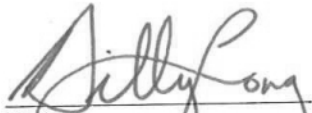
Donald Norcross
Member of Congress



Andy Harris, M.D.
Member of Congress



Ami Bera, M.D.
Member of Congress


Billy Long
Member of Congress

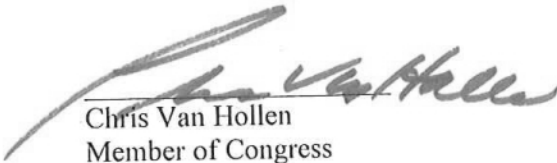

Hakeem Jeffries
Member of Congress

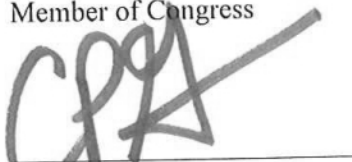


John K. Delaney
Member of Congress

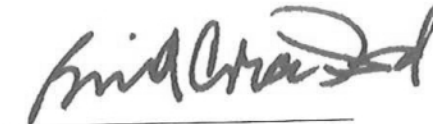


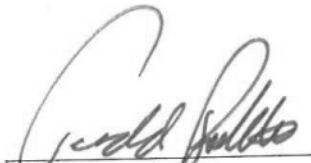
Dan Newhouse
Member of Congress

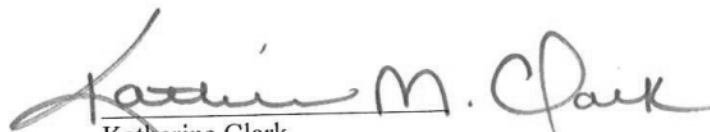

Chris Van Hollen
Member of Congress

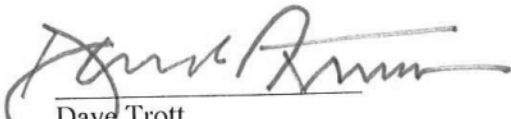

Chris Gibson
Member of Congress



Bill Johnson
Member of Congress



Rick Crawford
Member of Congress



Todd Rokita
Member of Congress

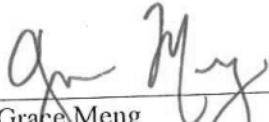

Katherine Clark
Member of Congress



Dave Trott
Member of Congress

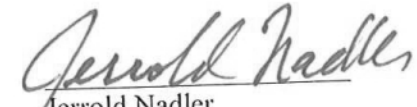

Daniel M. Donovan, Jr.
Member of Congress


David W. Jolly
Member of Congress

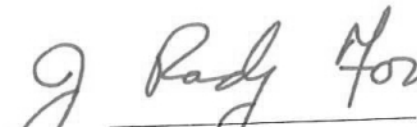

Rodney Davis
Member of Congress

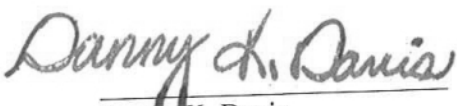

Grace Meng
Member of Congress

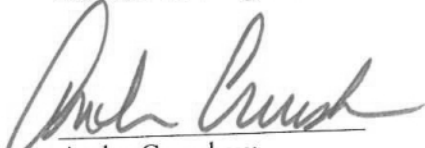

Vern Buchanan
Member of Congress

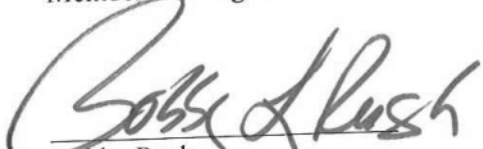

Jerrold Nadler
Member of Congress

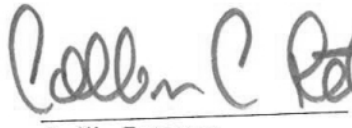

Gus M. Bilirakis
Member of Congress

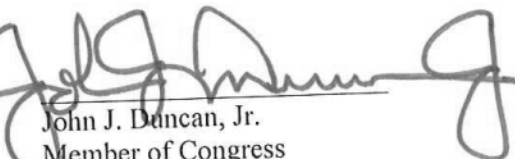

J Randy Forbes
Member of Congress


Danny K. Davis
Member of Congress

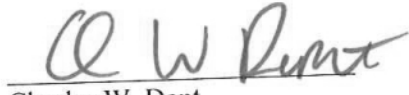

Ander Crenshaw
Member of Congress



Bobby Rush
Member of Congress

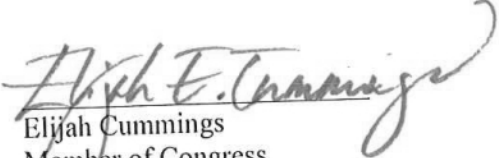

Collin Peterson
Member of Congress



John J. Duncan, Jr.
Member of Congress

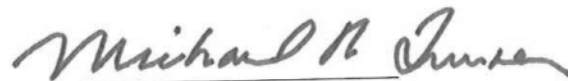

Steve King
Member of Congress

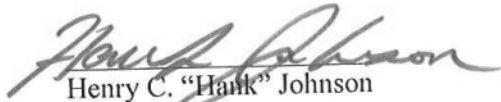

Charles W. Dent
Member of Congress


Joe Wilson
Member of Congress

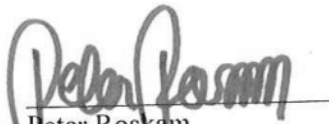

Elijah Cummings
Member of Congress

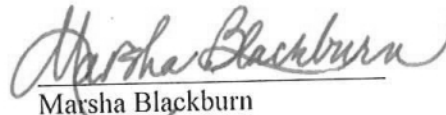

Gregory Meeks
Member of Congress

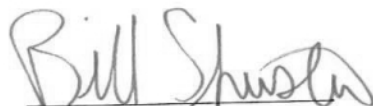

Michael R. Turner
Member of Congress

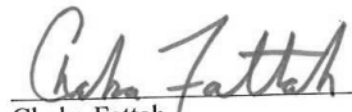

Henry C. "Hank" Johnson
Member of Congress

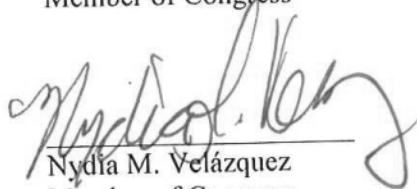

Adrian Smith
Member of Congress


Peter Roskam
Member of Congress


Marsha Blackburn
Member of Congress

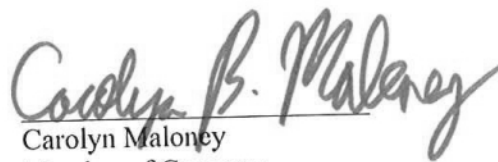

Bill Shuster
Member of Congress



Chaka Fattah
Member of Congress



Nydia M. Velázquez
Member of Congress



Peter Welch
Member of Congress


Rodney Frelinghuysen
Member of Congress



Carolyn B. Maloney
Member of Congress


Bob Goodlatte
Member of Congress

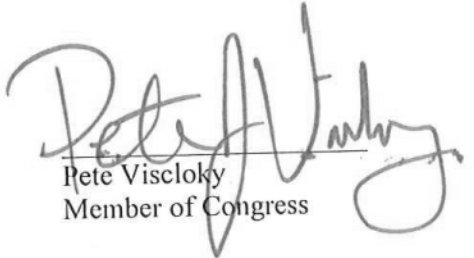

Edward R. Royce
Member of Congress




Kenny Marchant
Member of Congress



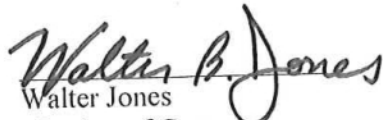
Don Young
Member of Congress



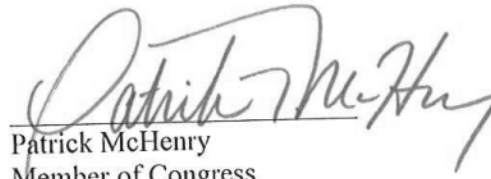
Pete Viscloky
Member of Congress




Linda T. Sánchez
Member of Congress



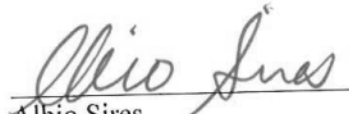
Walter Jones
Member of Congress



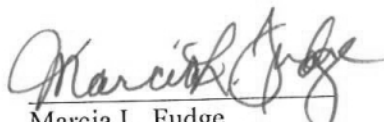
Patrick McHenry
Member of Congress



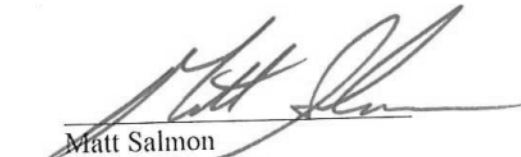
Michael C. Burgess M.D.
Member of Congress



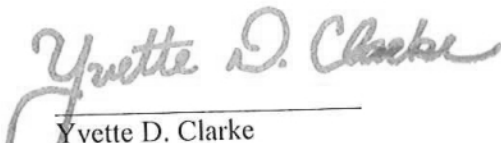
Albio Sires
Member of Congress



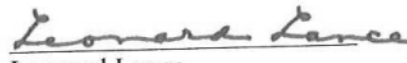
Marcia L. Fudge
Member of Congress



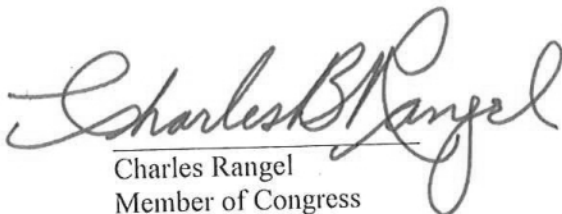
Matt Salmon
Member of Congress



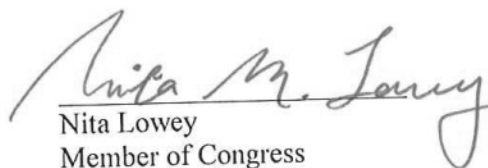
Yvette D. Clarke
Member of Congress



Leonard Lance
Member of Congress



Charles Rangel
Member of Congress



Nita Lowey
Member of Congress

Jan Schakowsky
Jan Schakowsky
Member of Congress

Diana DeGette
Diana DeGette
Member of Congress

Stephen F. Lynch
Stephen F. Lynch
Member of Congress

Steve Chabot
Steve Chabot
Member of Congress

Chris Smith
Chris Smith
Member of Congress

Michael Fitzpatrick
Michael Fitzpatrick
Member of Congress

Harold Rogers
Harold Rogers
Member of Congress

Sanford Bishop Jr.
Sanford Bishop
Member of Congress

Lamar Smith
Lamar Smith
Member of Congress

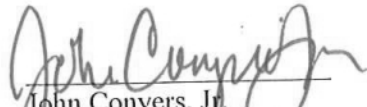
Adam B. Schiff
Adam B. Schiff
Member of Congress

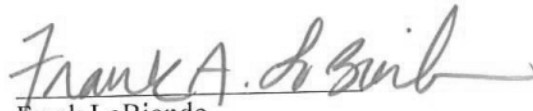
Dutch Ruppersberger
Dutch Ruppersberger
Member of Congress

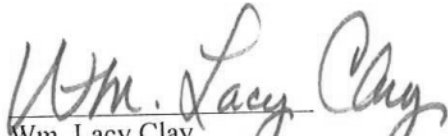
Austin Scott
Austin Scott
Member of Congress


Mick Mulvaney
Mick Mulvaney
Member of Congress

Kristi Noem
Kristi Noem
Member of Congress

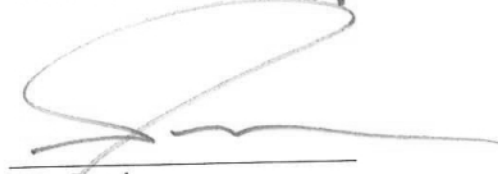

John Conyers, Jr.
Member of Congress

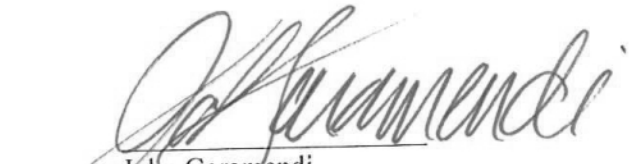

Frank LoBiondo
Member of Congress

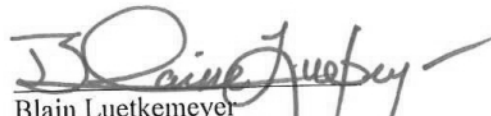

Wm. Lacy Clay
Member of Congress

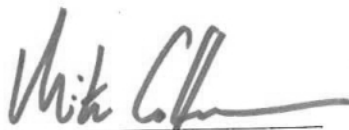

K. Michael Conaway
Member of Congress

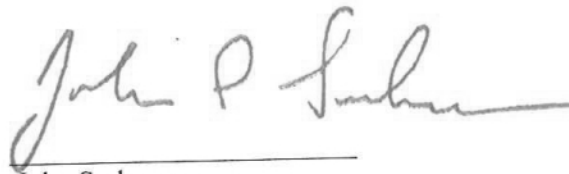

Brett Guthrie
Member of Congress

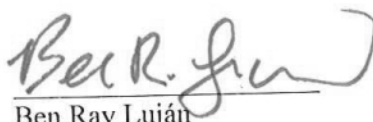

Tom Reed
Member of Congress



John Garamendi
Member of Congress


Blain Luetkemeyer
Member of Congress


Mike Coffman
Member of Congress



John Sarbanes
Member of Congress


Ben Ray Lujan
Member of Congress

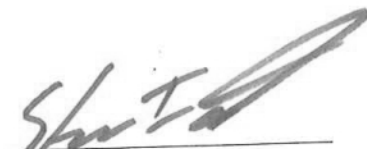

Ted Deutch
Member of Congress



Robert Latta
Member of Congress

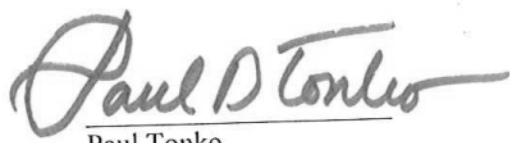

Andre' Carson
Member of Congress



Robert J. Wittman
Member of Congress

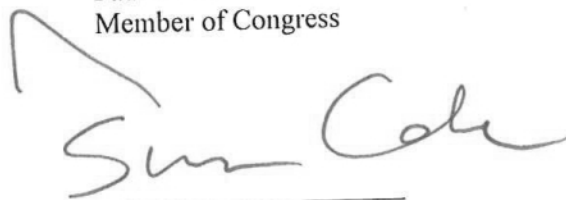

Randy Hultgren
Member of Congress

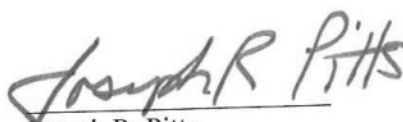

Steve Israel
Member of Congress



Brian Higgins
Member of Congress



Paul Tonko
Member of Congress


Darin LaHood
Member of Congress

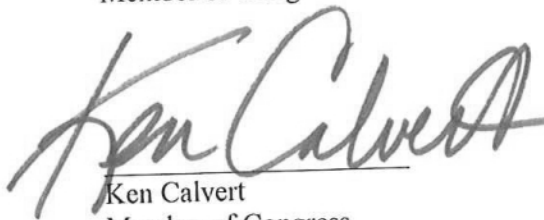

Tom Cole
Member of Congress

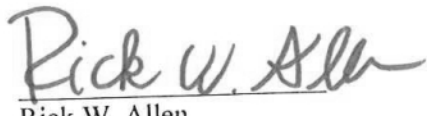

Joseph R. Pitts
Member of Congress



Jim Himes
Member of Congress

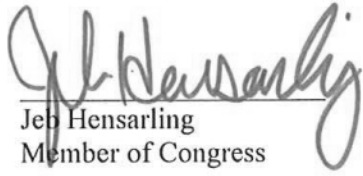

Cynthia Lummis
Member of Congress

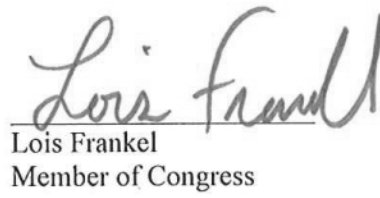

Ron Kind
Member of Congress



Ken Calvert
Member of Congress


Rick W. Allen
Member of Congress


Mike Thompson
Member of Congress


Jeb Hensarling
Member of Congress


Lois Frankel
Member of Congress


Raúl Grijalva
Member of Congress



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.


We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew M Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dave Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable John Larson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Larson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Diana DeGette
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeGette:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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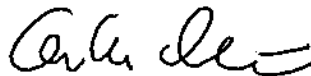
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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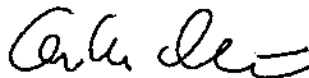
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable James R. Langevin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Langevin:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Glenn "GT" Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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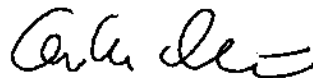
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Kevin Yoder
U.S. House of Representatives
Washington, DC 20515

Dear Representative Yoder:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Alan Grayson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grayson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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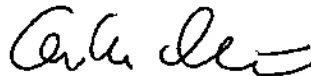
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Blaine Luetkemeyer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Luetkemeyer:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Mike Bost
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bost:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Tim Murphy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Rodney Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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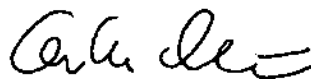
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Scott DesJarlais
U.S. House of Representatives
Washington, DC 20515

Dear Representative DesJarlais:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

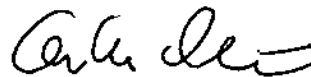
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Richard Hanna
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanna:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

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Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Paul D. Tonko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tonko:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dutch Ruppersberger
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ruppersberger:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,

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Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Biran Higgins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Higgins:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Pat Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Joyce Beatty
U.S. House of Representatives
Washington, DC 20515

Dear Representative Beatty:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

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Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kind:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.


We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable John J. Duncan, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duncan:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Chuck Fleischmann
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleischmann:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Richard E. Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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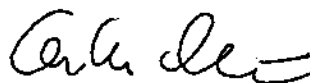
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable William R. Keating
U.S. House of Representatives
Washington, DC 20515

Dear Representative Keating:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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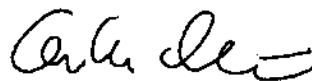
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Louise Slaughter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Slaughter:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Ann McLane Kuster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kuster:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable James P. McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

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Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Tammy Duckworth
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duckworth:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Joe Courtney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Courtney:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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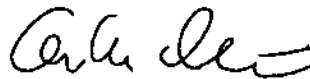
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Lou Barletta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barletta:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Alan Lowenthal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lowenthal:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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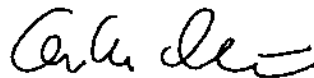
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Jim Cooper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cooper:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Bruce Westerman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westerman:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.


We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Billy Long
U.S. House of Representatives
Washington, DC 20515

Dear Representative Long:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



Administrator
Washington, DC 20201

The Honorable Bill Flores
U.S. House of Representatives
Washington, DC 20515

Dear Representative Flores:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Chellie Pingree
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pingree:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Tom Reed
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reed:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Henry C. "Hank" Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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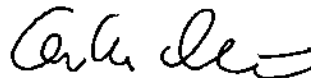
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Peter DeFazio
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeFazio:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Jared Polis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Polis:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dan Kildee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kildee:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Rosa DeLauro
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeLauro:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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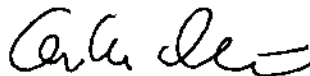
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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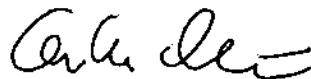
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable David N. Cicilline
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cicilline:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Stephen F. Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Lloyd Doggett
U.S. House of Representatives
Washington, DC 20515

Dear Representative Doggett:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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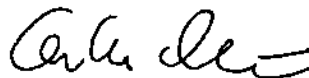
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Lynn Wesmoreland
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wesmoreland:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Keith Rothfus
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rothfus:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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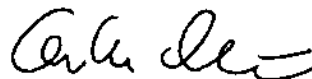
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We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Jim Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Matt Cartwright
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cartwright:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Cynthia Lummis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lummis:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Linda T. Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable P. James Sensenbrenner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sensenbrenner:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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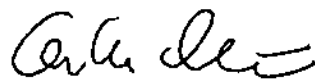
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Marc Veasey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Veasey:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Joe Crowley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crowley:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Bobby L. Rush
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rush:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Niki Tsongas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tsongas:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Jan Schakowsky
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schakowsky:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dana Rohrabacher
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rohrabacher:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Danny K. Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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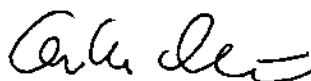
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Erik Paulsen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Paulsen:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Ileana Ros-Lehtinen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ros-Lehtinen:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable John L. Mica
U.S. House of Representatives
Washington, DC 20515

Dear Representative Mica:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dan Newhouse
U.S. House of Representatives
Washington, DC 20515

Dear Representative Newhouse:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Donald M. Payne, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Payne:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Katherine Clark
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clark:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Alcee L. Hastings
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hastings:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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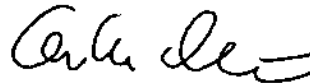
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Mark Pocan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pocan:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Peter King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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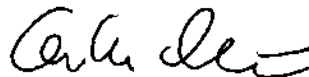
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Elizabeth H. Etsy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Etsy:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Henry Cuellar
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cuellar:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Dave Reichert
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reichert:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Suzan DelBene
U.S. House of Representatives
Washington, DC 20515

Dear Representative DelBene:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Joseph P. Kennedy, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kennedy:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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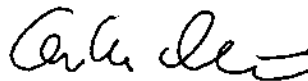
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Bill Foster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Foster:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Doug Lamborn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lamborn:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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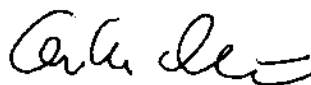
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable David Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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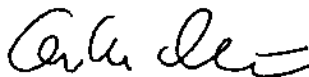
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Kathy Castor
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castor:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Nita Lowey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lowey:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Joaquin Castro
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castro:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

As part of the rulemaking process, and after carefully considering all of the public comments, we finalized that the fee schedule amounts for accessories used with different types of base equipment will be adjusted based on information from the competitive bidding programs for the accessories included in product categories that included some but not all of the different types of base equipment. We finalized that the adjusted fees for the accessories will be used in paying claims for the accessories in all cases, regardless of what type of base equipment is accommodating the added accessory. This avoids complexity and confusion associated with including the same accessory in multiple competitive bidding programs.

We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Doug Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a stylized flourish at the end.

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Rick Nolan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nolan:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grisham:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Jason Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Sam Graves
U.S. House of Representatives
Washington, DC 20515

Dear Representative Graves:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt".

Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

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Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stivers:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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Sincerely,



Andrew Slavitt
Acting Administrator



MAY 21 2015

Administrator
Washington, DC 20201

The Honorable Zoe Lofgren
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lofgren:

Thank you for your letter regarding Medicare payment for accessories used with complex rehabilitative wheelchairs. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for durable medical equipment (DME) based on information from the competitive bidding programs. The methodologies for adjusting fee schedule amounts for items subject to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program were promulgated through notice and comment rulemaking, as mandated by section 1834(a)(1)(G) of the Act. This rulemaking was part of the calendar year 2015 final rule published in the Federal Register on November 6, 2014, and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (79 FR 66120; CMS-1614-F).

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We do not believe that the cost of a wheelchair accessory varies significantly based on the type of wheelchair base accommodating the added accessory. The Healthcare Common Procedure Coding System (HCPCS) codes describe wheelchair accessories that are used interchangeably on different wheelchair bases. While there is always a range of products with different costs that fall under each HCPCS code, the Medicare payment amount represents payment for the category of items as a whole, and should be sufficient to cover the average costs of items falling under the code.

We recognize that Group 3 or higher complex rehabilitative power wheelchairs and related accessories furnished in connection with such wheelchairs are excluded from the competitive bidding programs under section 1847 of the Act. These items are therefore not included in any competitive bidding programs in effect today, and suppliers do not need to compete for contracts for furnishing Group 3 or higher complex rehabilitative power wheelchairs and accessories furnished in connection with these wheelchairs. However, the statute requires that the fee schedule amounts for items included under competitive bidding programs be adjusted based on information from the competitive bidding programs. With regard to wheelchair options and accessories, the fee schedule amounts established in accordance with section 1834 of the Act were established based on supplier charges or prices from 1986 for the accessories in general. We now have the ability to establish more reasonable payment rates for these items and services based on information related to the current costs of furnishing these items and services.

Finally, the CMS considered comments from stakeholders expressing concern about possible negative impacts the fee schedule adjustments might have on quality and access to items and services, especially in rural areas of the country. As part of the November 6, 2014, final rule (79 FR 66120; CMS-1614-F), 42 C.F.R. section 414.210(g)(9)(i) was established to phase in the adjustments on January 1, 2016, through June 30, 2016, based on 50 percent of the non-adjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts. This will allow a 6-month transition period where we can closely monitor health outcomes data and issues related to access to quality items and services at lower payment amounts.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I also will provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Slavitt", with a horizontal line extending from the end of the signature.

Andrew Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

April 20, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Acting Administrator Slavitt:

We are writing concerning a recent frequently asked questions (FAQ) document released by the Centers for Medicare and Medicaid Services (CMS) that could prevent Medicare beneficiaries with disabilities from receiving medically necessary complex rehab technology (CRT) as prescribed by their physician.

As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008, Section 154), Congress specifically excluded complex rehabilitative power wheelchairs, as well as the related accessories that beneficiaries used with those wheelchairs (such as seat/back cushions, recline/tilt systems, or specialty controls) from the Medicare durable medical equipment (DME) competitive bidding program. Accordingly, CMS did not include those items in Round 1 or Round 2 of the competitive bidding program. In addition, consistent with the spirit of that law, CMS excluded complex rehabilitative manual wheelchairs from Round 2 and implemented a similar policy for accessories used with these wheelchairs. As a result, complex rehabilitative wheelchairs and related accessories have continued to be paid at the established fee schedule amounts in bid and non-bid areas.

In November 2014, CMS issued final rule CMS 1614-F (Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies) to finalize changes to the Medicare DME competitive bidding program. Specifically, the final rule details how CMS will use information obtained from the competitive bidding program to adjust the established fee schedule amounts for competitively bid items provided in non-bid areas.

Following the issuance of that rule, CMS posted an FAQ document online in December. The FAQ document indicates that, starting in 2016, CMS intends to apply pricing information obtained from bids for standard wheelchair accessories to complex rehabilitative wheelchair accessories.

Applying competitive bidding pricing to complex rehabilitative wheelchair accessories is inconsistent with the intent of MIPPA 2008, which specifically exempted wheelchair accessories used with complex rehabilitative power wheelchairs from the competitive bidding program. The application of competitive bidding pricing to complex rehabilitative accessories is also contrary to CMS policies created following the legislation related to payment for complex rehab manual

wheelchair accessories. Clear precedent affirms that these items should continue to be paid at the established fee schedule amounts, as they are today and have been for more than six years during the operation of the competitive bidding program.

We are concerned about the potential negative impact on Medicare beneficiary access to complex rehabilitative wheelchairs and the important accessories used with these devices. A preliminary review of the affected codes indicates that a shift from the current fee schedule to bid program pricing could cut reimbursement to suppliers by 20 to 50 percent. Complex rehabilitative power and manual wheelchairs and the related accessories described above are used by people with serious disabilities including amyotrophic lateral sclerosis (ALS), cerebral palsy, multiple sclerosis, muscular dystrophy, spinal cord injury, and traumatic brain injury. This small population of Medicare beneficiaries with significant disabilities depend on these individually configured products to meet their unique medical needs and maximize their function and independence.

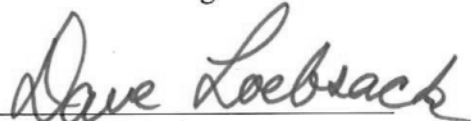
For the reasons discussed above, we urge CMS to review its decision to issue its December 2014 FAQ. We also request that CMS issue written clarification that accessories used with complex rehabilitative power and manual wheelchairs will continue to be paid at Medicare established fee schedule amounts and that such amounts will not be adjusted based on Medicare competitive bidding program pricing.

We appreciate your response by May 31.

Sincerely,



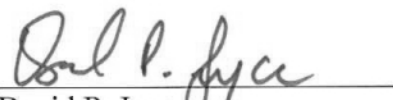
Bill Johnson
Member of Congress



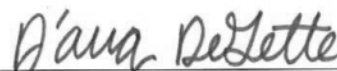
Dave Loebsack
Member of Congress



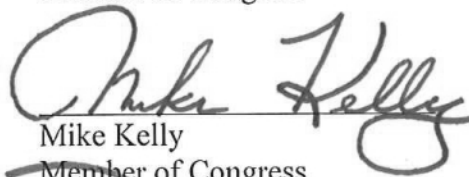
John Larson
Member of Congress



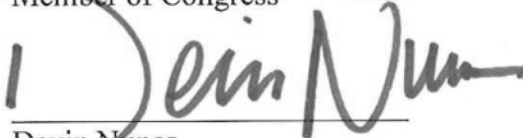
David P. Joyce
Member of Congress



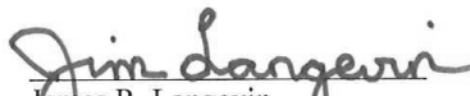
Diana DeGette
Member of Congress



Mike Kelly
Member of Congress



Devin Nunes
Member of Congress



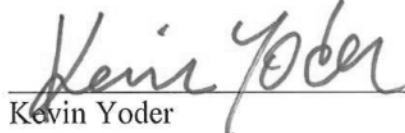
James R. Langevin
Member of Congress



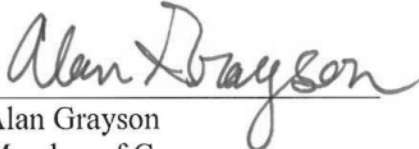
Glenn 'GT' Thompson
Member of Congress



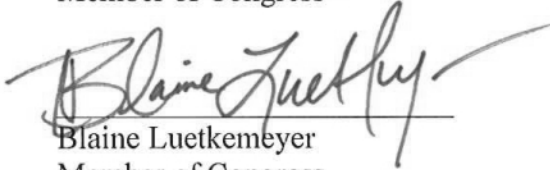
Marsha Blackburn
Member of Congress



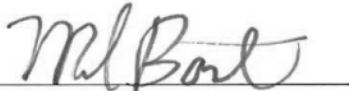
Kevin Yoder
Member of Congress



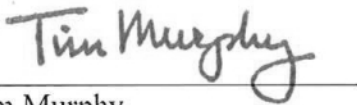
Alan Grayson
Member of Congress



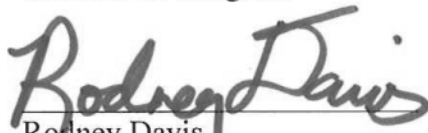
Blaine Luetkemeyer
Member of Congress



Mike Bost
Member of Congress



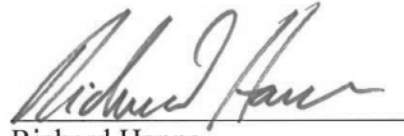
Tim Murphy
Member of Congress



Rodney Davis
Member of Congress



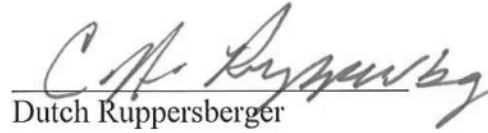
Scott DesJarlais
Member of Congress



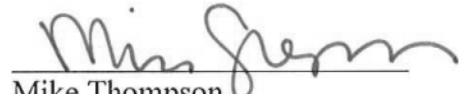
Richard Hanna
Member of Congress



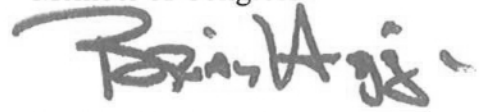
Paul D. Tonko
Member of Congress



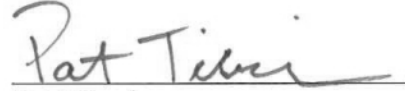
Dutch Ruppersberger
Member of Congress



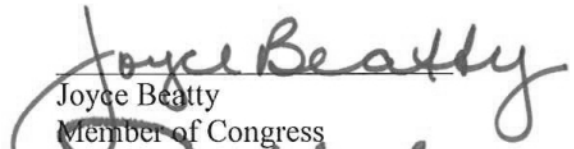
Mike Thompson
Member of Congress



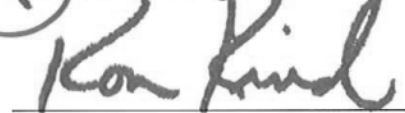
Brian Higgins
Member of Congress



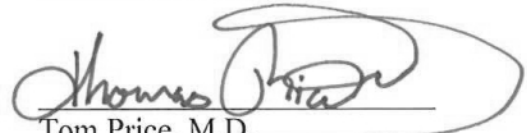
Pat Tiberi
Member of Congress



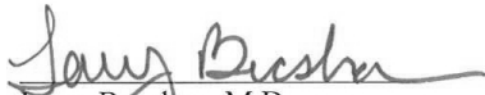
Joyce Beatty
Member of Congress

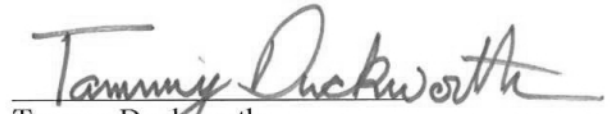


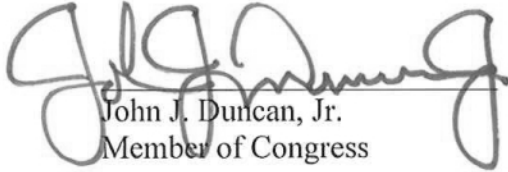
Ron Kind
Member of Congress




Tom Price, M.D.
Member of Congress


Larry Bucshon, M.D.
Member of Congress

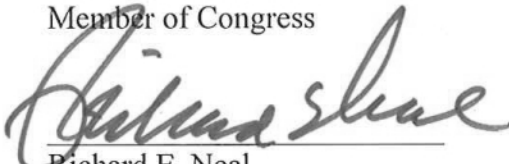

Tammy Duckworth
Member of Congress

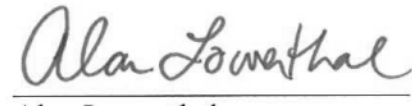

John J. Duncan, Jr.
Member of Congress

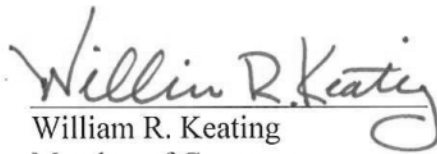

Joe Courtney
Member of Congress

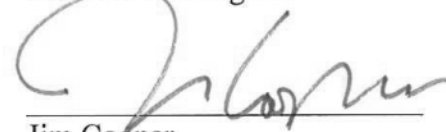

Chuck Fleischmann
Member of Congress


Lou Barletta
Member of Congress

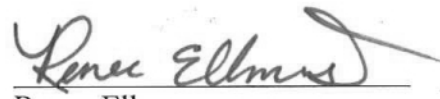

Richard E. Neal
Member of Congress

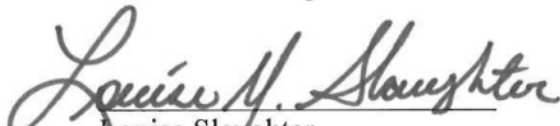

Alan Lowenthal
Member of Congress



William R. Keating
Member of Congress

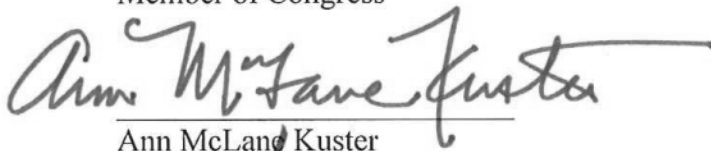

Jim Cooper
Member of Congress

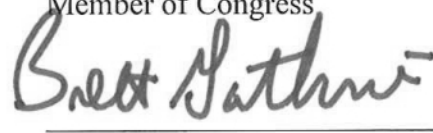

Gregg Harper
Member of Congress

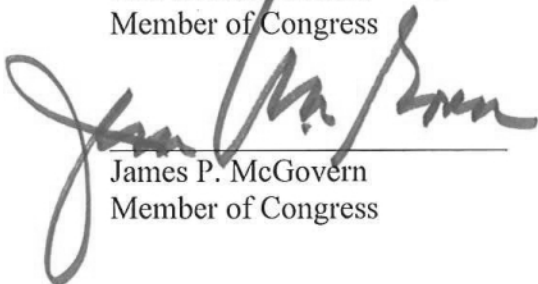

Renee Ellmers
Member of Congress

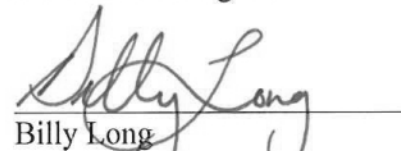

Louise Slaughter
Member of Congress


Bruce Westerman
Member of Congress


Ann McLane Kuster
Member of Congress


Brett Guthrie
Member of Congress


James P. McGovern
Member of Congress


Billy Long
Member of Congress



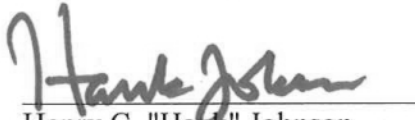
Bill Flores
Member of Congress



Chellie Pingree
Member of Congress



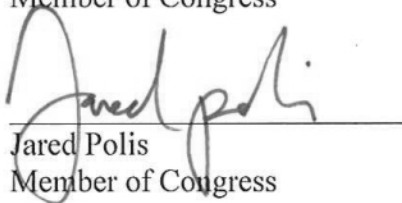
Tom Reed
Member of Congress



Henry C. "Hank" Johnson
Member of Congress



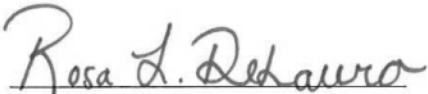
Peter DeFazio
Member of Congress



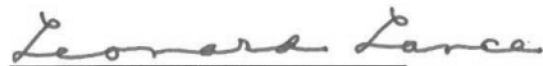
Jared Polis
Member of Congress




Dan Kildee
Member of Congress



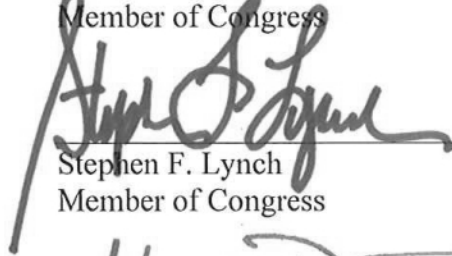
Rosa DeLauro
Member of Congress



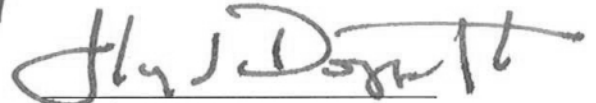
Leonard Lance
Member of Congress



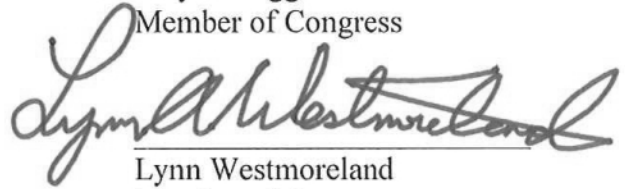
David N. Cicilline
Member of Congress



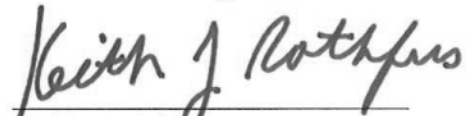
Stephen F. Lynch
Member of Congress



Lloyd Doggett
Member of Congress



Lynn Westmoreland
Member of Congress



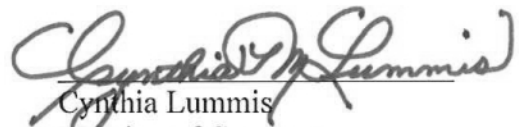
Keith Rothfus
Member of Congress



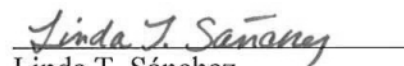
Jim Renacci
Member of Congress



Matt Cartwright
Member of Congress



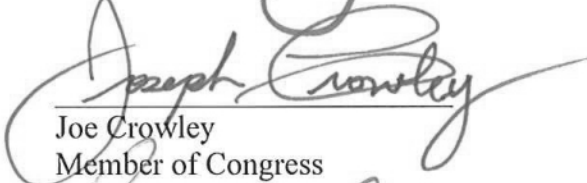
Cynthia Lummis
Member of Congress




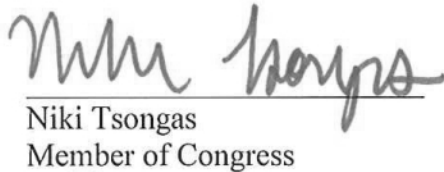
Linda T. Sánchez
Member of Congress

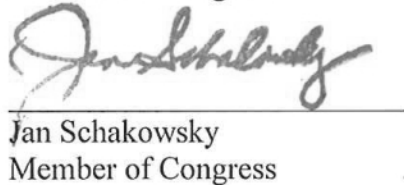

James Sensenbrenner
Member of Congress


Marc Veasey
Member of Congress

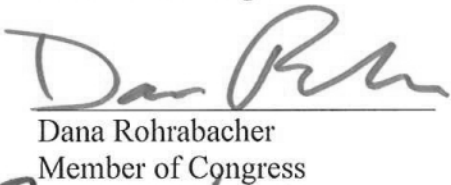

Joe Crowley
Member of Congress

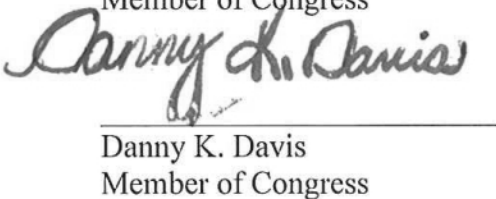

Bobby L. Rush
Member of Congress

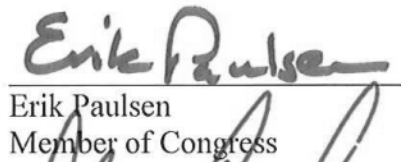

Niki Tsongas
Member of Congress

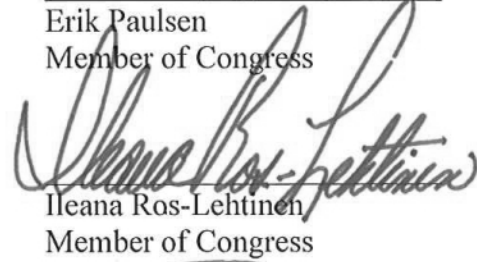

Jan Schakowsky
Member of Congress

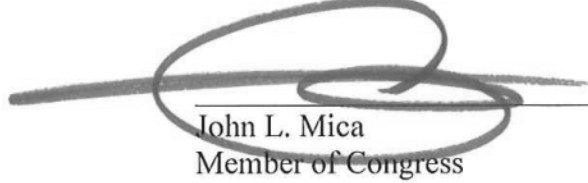

Chris Collins
Member of Congress

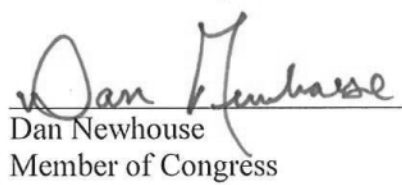

Dana Rohrabacher
Member of Congress

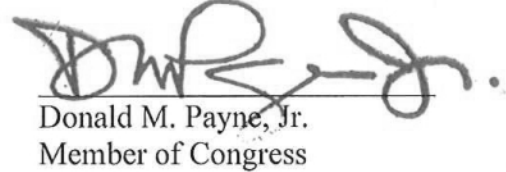

Danny K. Davis
Member of Congress

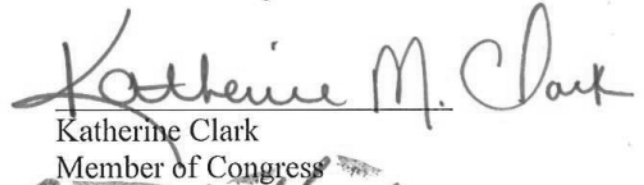

Erik Paulsen
Member of Congress

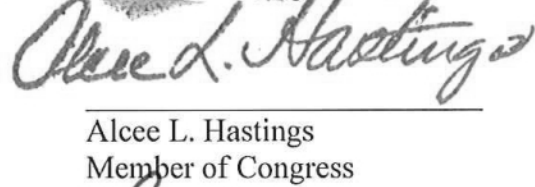

Ileana Ros-Lehtinen
Member of Congress

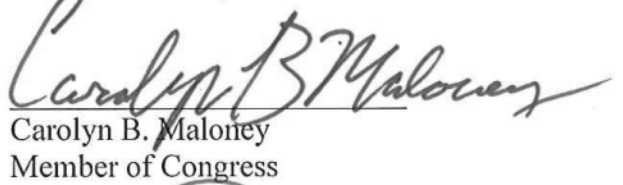

John L. Mica
Member of Congress

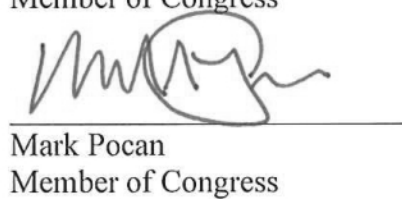

Dan Newhouse
Member of Congress


Donald M. Payne, Jr.
Member of Congress


Katherine Clark
Member of Congress


Alcee L. Hastings
Member of Congress


Carolyn B. Maloney
Member of Congress


Mark Pocan
Member of Congress



Peter King
Member of Congress



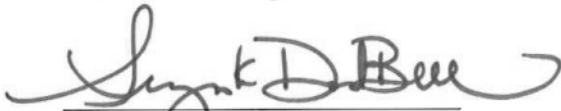
Elizabeth H. Esty
Member of Congress



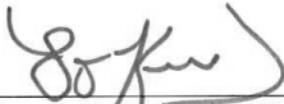
Henry Cuellar
Member of Congress



Dave Reichert
Member of Congress



Suzan DelBene
Member of Congress



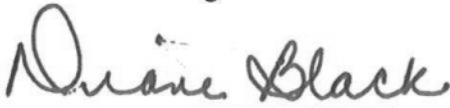
Joseph P. Kennedy, III
Member of Congress



Bill Foster
Member of Congress



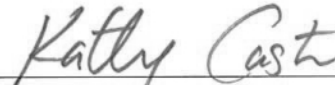
Doug Lamborn
Member of Congress



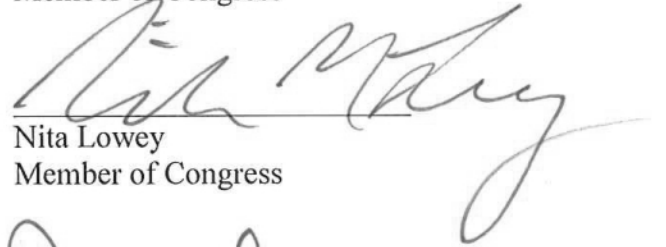
Diane Black
Member of Congress



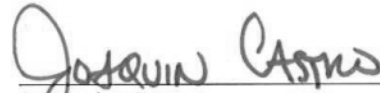
David Young
Member of Congress



Kathy Castor
Member of Congress



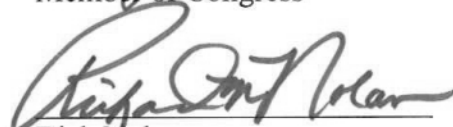
Nita Lowey
Member of Congress



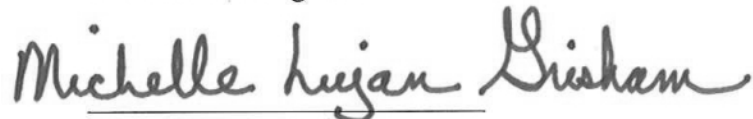
Joaquin Castro
Member of Congress



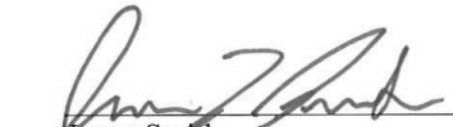
Doug Collins
Member of Congress



Rick Nolan
Member of Congress



Michelle Lujan Grisham
Member of Congress



Jason Smith
Member of Congress



Sam Graves
Member of Congress



Lynn Jenkins
Member of Congress



Zoe Lofgren
Member of Congress



Steve Stivers
Member of Congress



Administrator
Washington, DC 20201

JUL 30 2009

The Honorable Thomas E. Price
House of Representatives
Washington, DC 20515

Dear Mr. Price:

Thank you for your letter to President Obama regarding the Medicare coverage process. He has asked me to respond to you directly. We recognize and appreciate the importance of Medicare coverage of medically appropriate items and services for our beneficiaries. We also appreciate the difficult choices that must be made as Congress considers entitlement reform.

National coverage decisions (NCDs) are based on thorough reviews of the available clinical evidence. The Centers for Medicare & Medicaid Services (CMS) makes NCDs based on clinical effectiveness for a specific item or service. After review of all pertinent evidence, an item or service is covered if it is determined to be clinically effective for the Medicare beneficiary population (or a subset of that population). When the clinical evidence indicates that the item or service is clinically ineffective for our beneficiaries, there is no evidence, or the available evidence comes from poor-quality research studies, we do not cover the item or service under review. We are committed to keeping the coverage decision making process transparent and open to all. Final NCDs contain extensive documentation of the factors and evidence that are considered by CMS. The coverage process, from beginning to end, is posted on the CMS Web site with opportunities for the public to comment.

We do not currently take cost into consideration when we make a NCD. However, our long standing policy allows the Medicare contractors to consider the cost of an item or service (as one of many variables) in making a local coverage determination (LCD). There are also specific provisions in the Medicare statute allowing appeal of an LCD or its application to a particular reimbursement claim.

To assist us in making coverage decisions, CMS established the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), which provides advice resulting from a process of full scientific inquiry and thoughtful discussion, in an open forum, with careful framing of recommendations and clear identification of the basis for those recommendations. The committee is comprised of experts in clinical and administrative medicine, biologic and physical sciences, public health administration, patient advocacy, health care data and information management and analysis, health care economics, and medical ethics. The MEDCAC is used to supplement CMS' internal expertise and to ensure an unbiased and contemporary consideration of "state of the art" technology and science. The MEDCAC reviews and evaluates medical literature and technology assessments, and examines other available data and information. The MEDCAC assesses the strength of the available evidence and makes recommendations to CMS based on that evidence. The MEDCAC meetings are open to the public and allow public testimony.


Page 2 – The Honorable Thomas E. Price

The CMS may also commission an external technology assessment (TA) as part of the coverage review process. CMS commissions TAs to one of the Evidence-based Practice Centers within the Agency for Healthcare Research and Quality. Our Agency may commission a TA for a variety of reasons such as, when the body of evidence is so extensive that it would be difficult to complete a TA internally within the necessary time frames; an independent formulation of the appropriate assessment questions and methodological approach is desirable given the complexity or conflicting nature of the medical and scientific literature available; or there are significant differences in opinion among experts concerning the relevant evidence or in the interpretation of data, suggesting that an independent analysis would be valuable. The TA contains a review of the literature and may include a formal meta-analysis, which combines the results of multiple studies, when appropriate. We invite you to further review our coverage process at: <http://www.cms.hhs.gov/center/coverage.asp>.

I appreciate you sharing your concerns regarding this important issue. We also share your commitment to ensuring that Medicare beneficiaries have access to medically effective up-to-date, high quality health care, and to promoting a system in which patients and doctors can make informed decisions together, based on the best available evidence.

I will also provide this response to the cosigners of your letter.

Sincerely,


Charlene Frizzera
Acting Administrator

**THE WHITE HOUSE OFFICE
REFERRAL**

April 15, 2009

TO: DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACTION REQUESTED: APPROPRIATE ACTION

DESCRIPTION OF INCOMING:

ID: 1003236

MEDIA: LETTER

DOCUMENT DATE: March 10, 2009

TO: PRESIDENT OBAMA

FROM: THE HONORABLE CHARLES BOUSTANY
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBJECT: REQUESTS THAT THE PRESIDENT ISSUE AN EXECUTIVE ORDER STATING
MEDICARE MAY NOT USE COST DATA TO DEPRIVE SENIORS AND DISABLED
AMERICANS OF MEDICALLY NECESSARY CARE THROUGH ITS NATIONAL
COVERAGE DECISIONS

COMMENTS:

**PROMPT ACTION IS ESSENTIAL -- IF REQUIRED ACTION HAS NOT BEEN TAKEN WITHIN 9 WORKING DAYS OF RECEIPT,
UNLESS OTHERWISE STATED, PLEASE TELEPHONE THE UNDERSIGNED AT 456-2590.**

**RETURN ORIGINAL CORRESPONDENCE, WORKSHEET AND COPY OF RESPONSE (OR DRAFT) TO: DOCUMENT TRACKING UNIT,
ROOM 437, OFFICE OF RECORDS MANAGEMENT - THE WHITE HOUSE, 20500**

**THE WHITE HOUSE
 DOCUMENT MANAGEMENT AND
 TRACKING WORKSHEET**



DATE RECEIVED: April 07, 2009

CASE ID: 1003236

NAME OF CORRESPONDENT: THE HONORABLE CHARLES BOUSTANY

SUBJECT: REQUESTS THAT THE PRESIDENT ISSUE AN EXECUTIVE ORDER STATING MEDICARE
 MAY NOT USE COST DATA TO DEPRIVE SENIORS AND DISABLED AMERICANS OF
 MEDICALLY NECESSARY CARE THROUGH ITS NATIONAL COVERAGE DECISIONS

ROUTE TO: AGENCY/OFFICE	(STAFF NAME)	ACTION		DISPOSITION	
		CODE	DATE	TYPE RESPONSE	CODE
LEGISLATIVE AFFAIRS	PHIL SCHILIRO	ORG	04/07/2009		

ACTION COMMENTS:

✓ HHS

A 4/13/2009

ACTION COMMENTS:

ACTION COMMENTS:

ACTION COMMENTS:

ACTION COMMENTS:

COMMENTS: 45 ADDL SIGNEES

MEDIA TYPE: LETTER

USER CODE:

ACTION CODES	TYPE RESPONSE	DISPOSITION CODES	COMPLETED DATE
A = APPROPRIATE ACTION B = RESEARCH AND REPORT BACK D = DRAFT RESPONSE I = INFO COPY/NO ACT NECESSARY R = DIRECT REPLY W/ COPY ORG = ORIGINATING OFFICE	INITIALS OF SIGNER (W.H. STAFF) NRN = NO RESPONSE NEEDED OTBE = OVERTAKEN BY EVENTS	A = ANSWERED OR ACKNOWLEDGED C = CLOSED X = INTERIM REPLY	DATE OF ACKNOWLEDGEMENT OR CLOSEOUT DATE (MM/DD/YY)

KEEP THIS WORKSHEET ATTACHED TO THE ORIGINAL INCOMING LETTER AT ALL TIMES
 REFER QUESTIONS TO DOCUMENT TRACKING UNIT (202)-456-2590
 SEND ROUTING UPDATES AND COMPLETED RECORDS TO OFFICE OF RECORDS MANAGEMENT - DOCUMENT TRACKING UNIT
 ROOM 437, EEOB.

SCANNED
 BY
 ORM

Congress of the United States
Washington, DC 20515

March 10, 2009

President Barack Obama
The White House
Washington, DC 20500

Dear Mr. President,

During your recent speech before the joint session of Congress, you mentioned the need for Congress to work to “bring down costs” in health care. At the fiscal responsibility summit, you also challenged leaders from both parties to confront the “hard choices” required by meaningful entitlement reform.

We believe Congressional leaders from both parties have a duty to achieve this goal without depriving patients of medically-necessary care – especially in Medicare where seniors have no other coverage options.

Accordingly, we respectfully request that you issue an executive order stating Medicare may not use cost data to deprive seniors and disabled Americans of medically necessary care through its national coverage decisions.

The economic stimulus package and omnibus bill provided a combined total of \$1.15 billion for clinical-effectiveness research and cost-effectiveness analysis. Report language from the conference agreement on the stimulus notes that data from this research may not be used to require or “mandate” Medicare coverage. Unfortunately, the final agreement excluded language from the Senate bill preventing Medicare from using this data to “withhold coverage.” As a result, the law does not prevent Medicare from denying coverage for needed care solely due to cost.

Medicare twice attempted to change rules to permit the agency to formally use cost data in national coverage decisions to narrow coverage for safe and effective care. In doing so, the agency argued it only had authority to pay for “reasonable” services. Groups like AARP successfully resisted these attempts. AARP clarifies that: “Comparative effectiveness is intended to help consumers and providers determine the best treatment – not just the least costly... This information should not be used as a means to deny individuals access to appropriate therapeutic options.”

In addition, the Congressional Black Caucus – focusing in particular on the exacerbating of health inequities across subpopulation groups – expressed concerns that this research should not be “used as rationale for limiting care to what works on average, rather than what works best for each, individual patient.” The Congressional New Democrats also

stated that they preferred bill language that “protects against the use of this research to deny access to care solely based on cost” and urged House Leadership to “ensure that clinical effectiveness and medical outcomes are the focus of comparative effectiveness research funding.”

Experts on cost-effectiveness analysis argue it will be impossible to ignore any cost data generated by federally-funded research when making national coverage decisions. A White House executive order establishing reasonable protections for Medicare patients would help to ensure Medicare reform remains patient-centered.

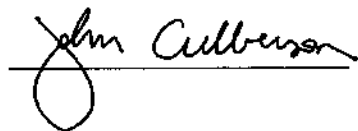
To bring needed transparency to the Medicare coverage process and to help make sure these decisions are based on sound clinical logic, we also ask you to require CMS to bring its coverage decisions before standing committees of clinical experts, similar to the FDA advisory committee process, when the agency proposes to narrow coverage for a medical product or service. Members of this advisory committee should have an expertise in the clinical areas that reflect the type of product and condition in question.

We look forward to working with you on this important issue.

Sincerely,



Charles Blumenthal

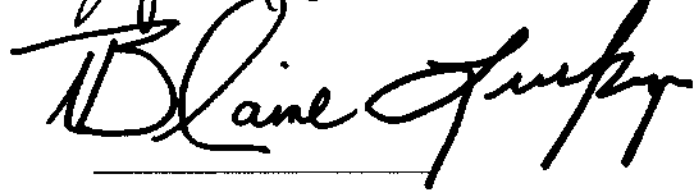

John P. Chitt


John Culberson

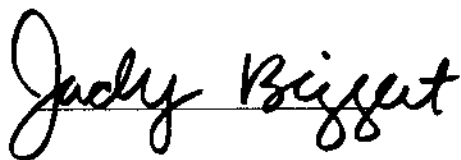

John Boozma

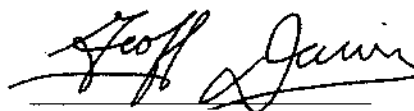

Michael Pittman


Lynn Stuenkel


Blaine Luntz


Bob Latta


Judy Biggert


Geoff Davis

Yvette D. Clarke

Clara Kim

John Fleming

Eleanor H. Norton

John J. Lee

Donald Payne

Bobby Lee

Sam Lee

Ellen Anderson

Konrad Blum

John Linn

Marcia L. Judge
Sunny & Anne

Gregory W. White

John Long Jr

John II-19

Bobby L. Bush

B. B. Inglis

Wally Herger

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Paul Ryan

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Joseph Pitts

Thomas P.

David P. Roe

Gary Boatwright

Bill Conroy

Paul Job

Pat Liberi

Phil Singrey

Dean Heller

Mike Rogers (MI-08)

Glen Thompson



JUN - 3 2013

Administrator
Washington, DC 20201

The Honorable Tom Price, MD
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the application of the two percent sequestration reductions required under the Budget Control Act of 2011 to payment for Medicare Part B drugs. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

Your letter asks a number of specific questions including our authority for setting Part B drug payment rates as well as whether any flexibility exists in how we implement the sequestration reductions. Generally, the Medicare payment methodology for Part B drugs and biologicals is described in section 1847A of the Social Security Act. This section specifies that Medicare's payment allowance is 106 percent of the Average Sales Price (ASP). The sequestration reductions are applied to the Medicare payment portion after subtracting beneficiary coinsurance.

The following hypothetical example illustrates how sequestration is applied:

Payment Calculation:

ASP	\$943.40
106% of ASP	\$1,000
Beneficiary Coinsurance	\$200
Pre-Sequestration Medicare Payment Portion:	\$800
Medicare Payment Portion after 2% Sequester	\$784

Total Payment to Physician before Sequester:

Medicare	\$800
Beneficiary	\$200
Total	\$1,000

Total Payment to Physician after Sequester:

Medicare	\$784
Beneficiary	\$200
Total	\$984

In the example above, assuming the beneficiary has met the deductible, the beneficiary's coinsurance of 20 percent (\$200) is subtracted from the Medicare allowance of \$1,000 for the

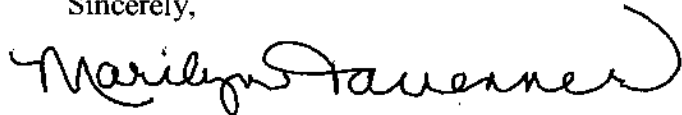
Page 2 – The Honorable Tom Price, MD

drug (106 percent of the ASP). The resulting amount of \$800, which is the Medicare payment portion, is then reduced by the two percent sequester reduction to \$784. The sum of the Medicare payment of \$784 and the beneficiary coinsurance of \$200 equals a total payment to the physician of \$984 (or a reduction of 1.6 percent from the \$1,000 that would otherwise be paid to the physician). In this example, net of the sequestration, the physician payment of \$984 would equal 104.3 percent more than the ASP.

The Department of Health and Human Services assessed whether the law allows discretion to administer the sequestration reductions in a manner that is different from the across the board approach that has been used to implement it. We do not believe that we have the authority under the Budget Control Act of 2011 to exempt Medicare payment for Part B drugs. Exemptions from the sequestration are specified in 2 U.S.C. sections 905(g) and (h) and 906(d)(7), which do not encompass payment for Medicare Part B drugs. The Office of Management and Budget memorandums M-13-03 and M-13-06 referenced in your letter pertain to any flexibility regarding the agency's budgetary resources for internal operations such as the hiring of new employees. This is separate from the agency's administration of Medicare payments, which are subject to the sequestration reductions, as noted above.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

April 19, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Tavenner:

We write regarding the two percent sequestration reduction to Medicare payments to providers – particularly those caring for cancer patients – effective April 1, 2013. We are concerned about how this cut will be implemented and if there is any flexibility available to your agency in how the cut is applied to the payments. Unencumbered access to critical cancer medicines for Medicare beneficiaries is a top priority for us and we would like to work with you to find a path forward that does not result in cancer patients being turned away by their oncologists.

As you know, the Medicare Modernization Act of 2003 (MMA) changed the pricing for cancer drugs covered under Medicare Part B to Average Sale Price (ASP) plus six percent. The intent was to reimburse cancer clinics and other providers for their drug acquisition costs at average market rates and to include an additional services payment (i.e., 6%) to cover inventory, facilities, storage, handling and waste disposal costs.

Our concerns are two-fold. First, it is unclear to us if the Centers for Medicare and Medicaid Services (CMS) has the statutory authority to reduce Medicare Part B drug reimbursement since the amount is specified in the MMA. Second, concerning sequestration, the Office of Management and Budget (OMB) has issued guidance instructing federal agencies and departments to, “[u]se any available flexibility to reduce operational risks and minimize impacts on the agency’s core mission in service of the American people...”¹ Per a March 1, 2013, OMB memorandum notifying all federal departments and agencies of the sequestration order, “Agencies should operate in a manner that is consistent with guidance provided by OMB in Memorandum 13-03...”² We would like to see CMS use any flexibility that exists to implement the cuts in such a way that the core mission of the agency – to provide care to beneficiaries – is retained and protected.

¹ OMB M-13-03, “Memorandum for the Heads of Executive Departments and Agencies,” Office of Management and Budget (OMB) website, <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-03.pdf>, January 14, 2013

² OMB M-13-06, “Memorandum for the Heads of Executive Departments and Agencies,” OMB website, <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-06.pdf>, March 1, 2013

It was reported in the news that cancer clinics across the country are already turning away thousands of Medicare patients advising them to seek treatment elsewhere, citing the Medicare sequester cuts that took effect April 1.^[2] Our hope is that there is a solution that neither diminishes the access of beneficiaries to the treatments they need nor their ability to seek needed treatment in the setting of their choice. We would like more information on this issue from CMS and request your help in addressing the following:

- 1) Are Medicare Part B drug reimbursement rates set in statute?
- 2) Does CMS have, and if so, intend to use the authority to reduce Medicare Part B drug reimbursements?
- 3) Will CMS be monitoring access to care for Medicare beneficiaries once the sequester takes effect – particularly for services where interruption or delay could mean success or failure of treatment, such as cancer care? What steps has CMS taken to avoid negatively affecting Medicare beneficiaries receiving chemotherapy and other specialty infusible drugs?
- 4) Does CMS believe any flexibility exists to modify cuts in areas where access barriers become present?
- 5) How will CMS calculate the reduction required under the sequester? Will it apply to the entire payment for the drug (ASP+6%) or only the base ASP amount, or only to the +6%?
- 6) Has CMS reviewed the potential program costs and impact on Medicare beneficiaries that the reduction required by the sequester may cause? For example, will reduced access to cancer clinics cause beneficiaries to seek services in higher-cost sites of care?
- 7) Have you received or collected any information about Medicare beneficiaries, to date, being turned away from their healthcare provider due to uncertainty about the future reimbursement rates for their Part B drugs?

We ask that you answer the questions posed and if ultimately this cut is applied, use any and all flexibility available to you to ensure a potential sequester cut is applied to just the 6 percent service payment and not to the underlying fixed drug cost (ASP). We are asking, therefore, that any available flexibility be used to direct the cuts away from patients. Our hope is that there is a solution that protects patients' access to their healthcare professionals. We look forward to working with you to implement impending spending reductions in a way that does not threaten needed access to care for Medicare beneficiaries.

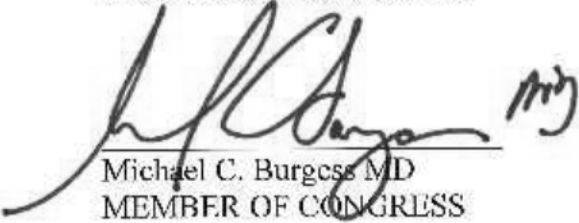
Thank you again for your attention to this important matter. In light of the sequester implementation on April 1, we kindly request that you provide a response to this letter on or before April 29, 2013.

Sincerely,

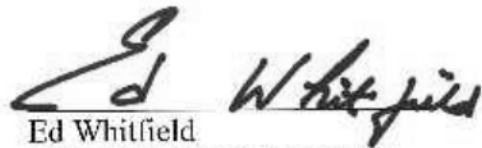
² Sarah Kliff, "Cancer clinics are turning away thousands of Medicare patients. Blame the sequester," *The Washington Post's Wonkblog*, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/03/cancer-clinics-are-turning-away-thousands-of-medicare-patients-blame-the-sequester/>, April 3, 2013.



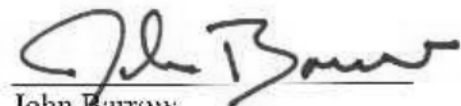
Pete Sessions
MEMBER OF CONGRESS



Michael C. Burgess MD
MEMBER OF CONGRESS



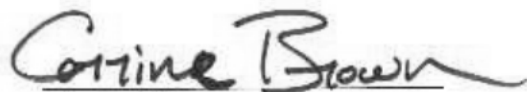
Ed Whitfield
MEMBER OF CONGRESS



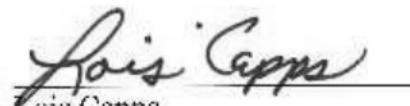
John Barrow
MEMBER OF CONGRESS



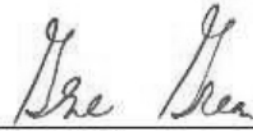
Sanford D. Bishop, Jr.
MEMBER OF CONGRESS



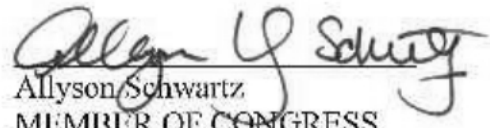
Corrine Brown
MEMBER OF CONGRESS



Lois Capps
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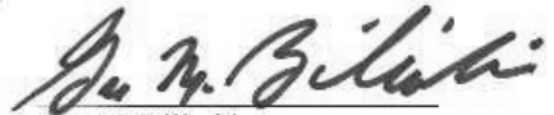
Gene Green
MEMBER OF CONGRESS



Allyson Schwartz
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Ron Kind
MEMBER OF CONGRESS



Gus M. Bilirakis
MEMBER OF CONGRESS




Bruce L. Braley
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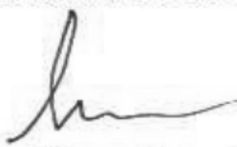


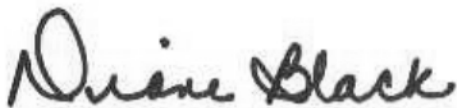
G.K. Butterfield
MEMBER OF CONGRESS




Steve Chabot
MEMBER OF CONGRESS

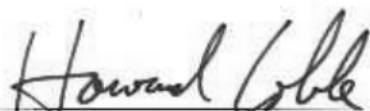

Joyce Beatty
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Ami Bera, MD
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Diane Black
MEMBER OF CONGRESS


Madeline Z. Bordallo
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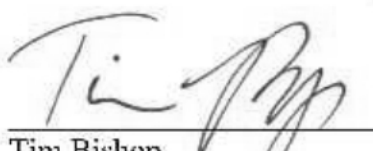

John Carter
MEMBER OF CONGRESS

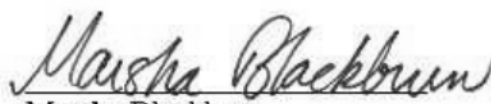

Howard Coble
MEMBER OF CONGRESS

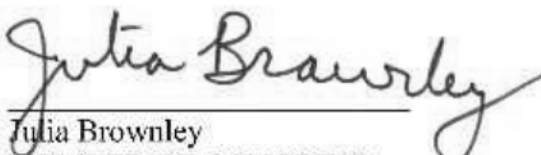

Jim Cooper
MEMBER OF CONGRESS

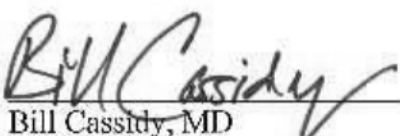

Peter A. DeFazio
MEMBER OF CONGRESS


Jim Bridenstine
MEMBER OF CONGRESS


Tim Bishop
MEMBER OF CONGRESS



Marsha Blackburn
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Julia Brownley
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Joe Courtney
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Suzan DelBene
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Tammy Duckworth

Tammy Duckworth
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Renee Ellmers

Renee Ellmers
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Michael G. Fitzpatrick

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Bill Flores

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Randy J. Forbes

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Jeff Fortenberry

Jeff Fortenberry
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Cory Gardner

Cory Gardner
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Jim Gerlach

Jim Gerlach
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Bob Gibbs

Bob Gibbs
MEMBER OF CONGRESS

Phil Gingrey, MD

Phil Gingrey, MD
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Bob Goodlatte

Bob Goodlatte
MEMBER OF CONGRESS

Trey Gowdy

Trey Gowdy
MEMBER OF CONGRESS

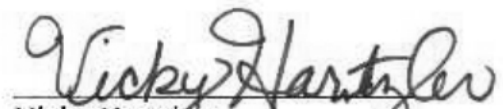
H. Morgan Griffith

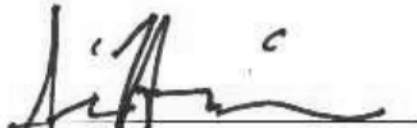
H. Morgan Griffith
MEMBER OF CONGRESS


Ralph Hall

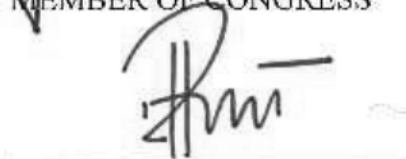
Ralph Hall
MEMBER OF CONGRESS

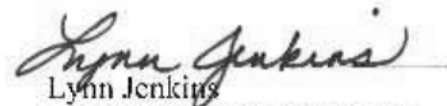

Gregg Harper
MEMBER OF CONGRESS



Vicky Hartzler
MEMBER OF CONGRESS

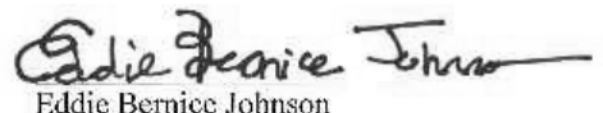

Jim Himes
MEMBER OF CONGRESS

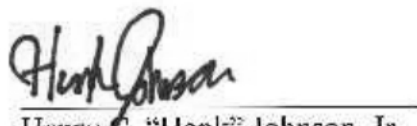

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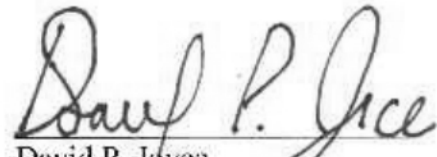

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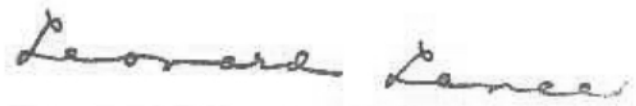

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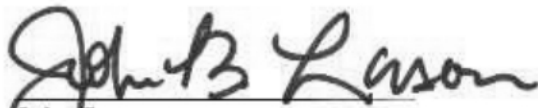

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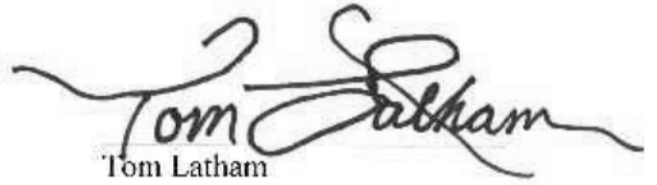

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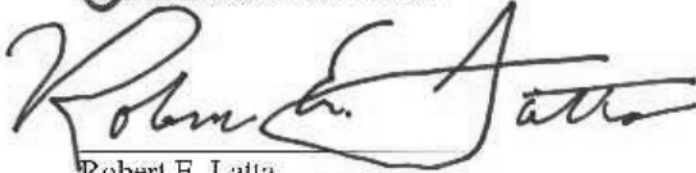

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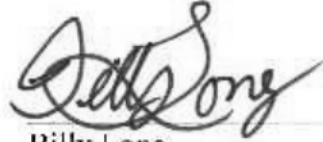
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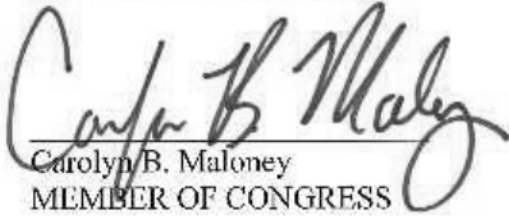
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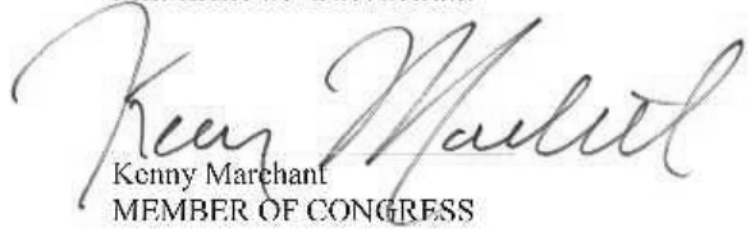
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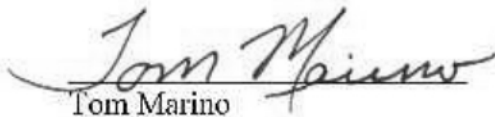
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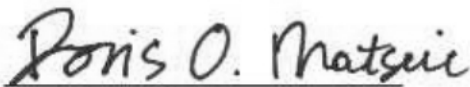
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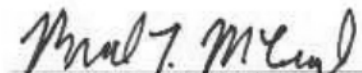
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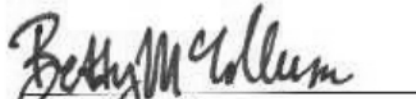
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Betty McCollum
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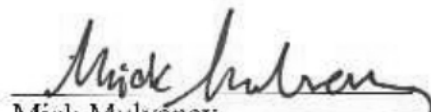

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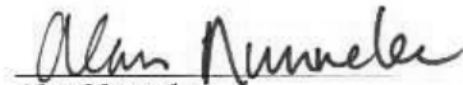

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Markwayne Mullin
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Mick Mulvany
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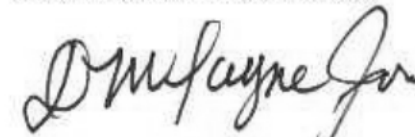

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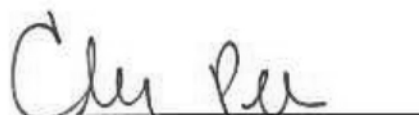

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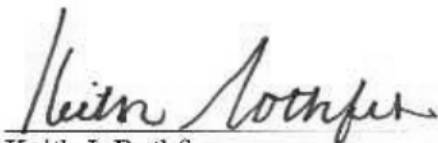
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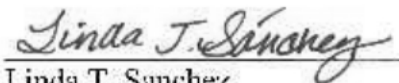
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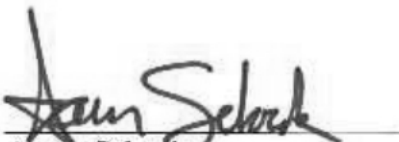
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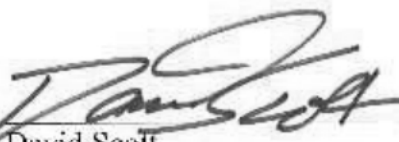
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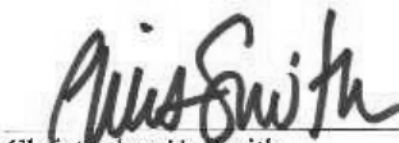
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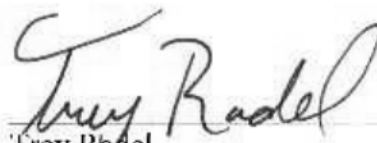
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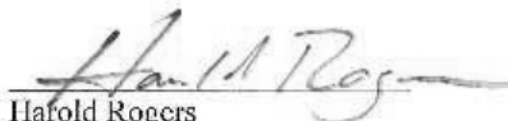
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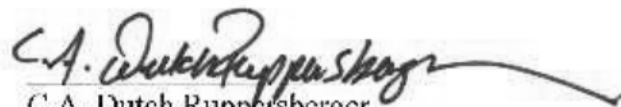
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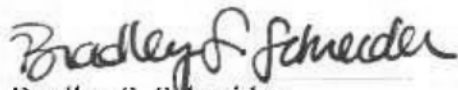
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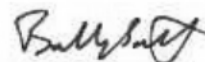
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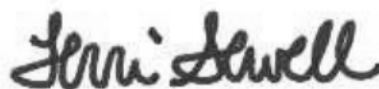
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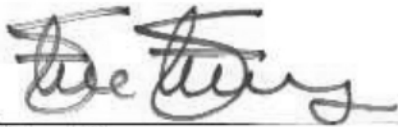
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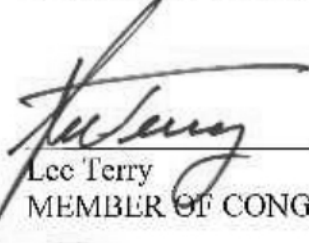
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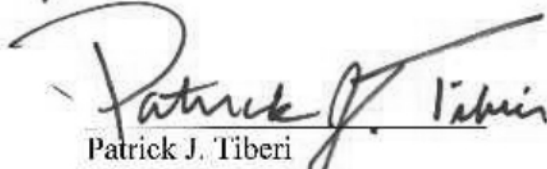
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Eric Swalwell
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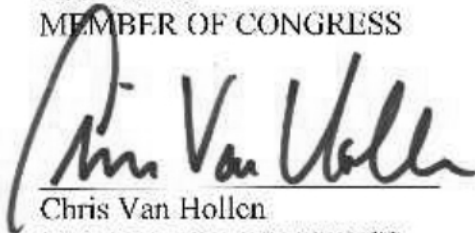
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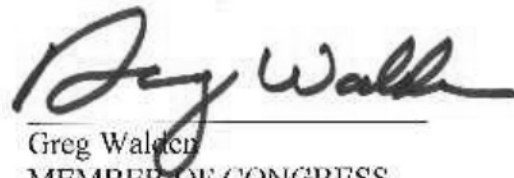
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Paul Tonko
MEMBER OF CONGRESS



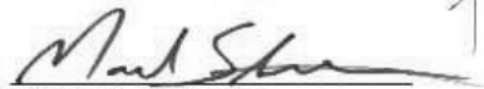
Chris Van Hollen
MEMBER OF CONGRESS



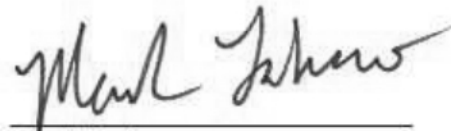
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MEMBER OF CONGRESS



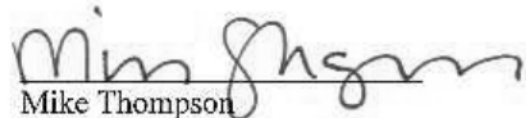
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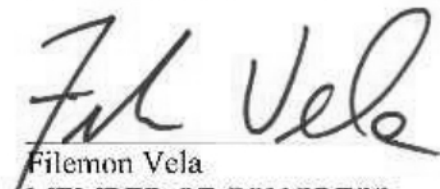
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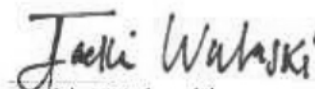
Scott R. Tipton
MEMBER OF CONGRESS



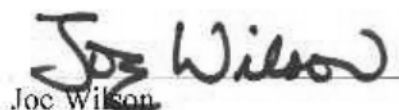
Michael R. Turner
MEMBER OF CONGRESS



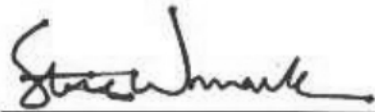
Filemon Vela
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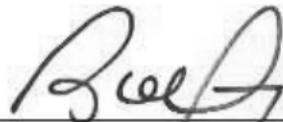
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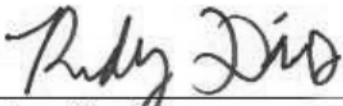
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Congress of the United States
House of Representatives
Washington, DC 20515-2303

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FAX: (202) 225-6351
DISTRICT OFFICE
250 PRAIRIE CENTER DRIVE
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OSORA, DIVISION OF
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MANAGEMENT

April 24, 2013

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Tavenner:

I would like to echo the concerns of my colleagues who wrote to you earlier this week regarding the two percent sequestration reduction to Medicare payments to providers – particularly those caring for cancer patients – effective April 1, 2013. I share their concerns about how this cut will be implemented and if there is any flexibility available to your agency in how the cut is applied to the payments. Unencumbered access to critical cancer medicines for Medicare beneficiaries is a top priority for us and we would like to work with you to find a path forward that does not result in cancer patients being turned away by their oncologists.

I have enclosed their letter, dated April 19, 2013. Please copy my office on responses to the following questions:

Are Medicare Part B drug reimbursement rates set in statute?

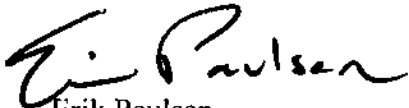
- 1) Does CMS have, and if so, intend to use the authority to reduce Medicare Part B drug reimbursements?
- 2) Will CMS be monitoring access to care for Medicare beneficiaries once the sequester takes effect – particularly for services where interruption or delay could mean success or failure of treatment, such as cancer care? What steps has CMS taken to avoid negatively affecting Medicare beneficiaries receiving chemotherapy and other specialty infusible drugs?
- 3) Does CMS believe any flexibility exists to modify cuts in areas where access barriers become present?
- 4) How will CMS calculate the reduction required under the sequester? Will it apply to the entire payment for the drug (ASP+6%) or only the base ASP amount, or only to the +6%?
- 5) Has CMS reviewed the potential program costs and impact on Medicare beneficiaries that the reduction required by the sequester may cause? For example, will reduced

access to cancer clinics cause beneficiaries to seek services in higher-cost sites of care?

- 6) Have you received or collected any information about Medicare beneficiaries, to date, being turned away from their healthcare provider due to uncertainty about the future reimbursement rates for their Part B drugs?

Please answer the questions posed and, if ultimately this cut is applied, use any and all flexibility available to you to ensure a potential sequester cut is applied to just the 6 percent service payment and not to the underlying fixed drug cost (ASP). My colleagues and I are asking, therefore, that any available flexibility be used to direct the cuts away from patients. Our hope is that there is a solution that protects patients' access to their healthcare professionals. We look forward to working with you to implement impending spending reductions in a way that does not threaten needed access to care for Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink that reads "Erik Paulsen". The signature is fluid and cursive, with the first name "Erik" and last name "Paulsen" clearly distinguishable.

Erik Paulsen
MEMBER OF CONGRESS

Congress of the United States
Washington, DC 20515

April 19, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Tavenner:

We write regarding the two percent sequestration reduction to Medicare payments to providers – particularly those caring for cancer patients – effective April 1, 2013. We are concerned about how this cut will be implemented and if there is any flexibility available to your agency in how the cut is applied to the payments. Unencumbered access to critical cancer medicines for Medicare beneficiaries is a top priority for us and we would like to work with you to find a path forward that does not result in cancer patients being turned away by their oncologists.

As you know, the Medicare Modernization Act of 2003 (MMA) changed the pricing for cancer drugs covered under Medicare Part B to Average Sale Price (ASP) plus six percent. The intent was to reimburse cancer clinics and other providers for their drug acquisition costs at average market rates and to include an additional services payment (i.e., 6%) to cover inventory, facilities, storage, handling and waste disposal costs.

Our concerns are two-fold. First, it is unclear to us if the Centers for Medicare and Medicaid Services (CMS) has the statutory authority to reduce Medicare Part B drug reimbursement since the amount is specified in the MMA. Second, concerning sequestration, the Office of Management and Budget (OMB) has issued guidance instructing federal agencies and departments to, “[u]se any available flexibility to reduce operational risks and minimize impacts on the agency’s core mission in service of the American people...”^[1] Per a March 1, 2013, OMB memorandum notifying all federal departments and agencies of the sequestration order, “Agencies should operate in a manner that is consistent with guidance provided by OMB in Memorandum 13-03...”^[2] We would like to see CMS use any flexibility that exists to implement the cuts in such a way that the core mission of the agency – to provide care to beneficiaries – is retained and protected.

¹ OMB M-13-03, “Memorandum for the Heads of Executive Departments and Agencies,” Office of Management and Budget (OMB) website, <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-03.pdf>, January 14, 2013

² OMB M-13-06, “Memorandum for the Heads of Executive Departments and Agencies,” OMB website, <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-06.pdf>, March 1, 2013

It was reported in the news that cancer clinics across the country are already turning away thousands of Medicare patients advising them to seek treatment elsewhere, citing the Medicare sequester cuts that took effect April 1.¹²¹ Our hope is that there is a solution that neither diminishes the access of beneficiaries to the treatments they need nor their ability to seek needed treatment in the setting of their choice. We would like more information on this issue from CMS and request your help in addressing the following:

- 1) Are Medicare Part B drug reimbursement rates set in statute?
- 2) Does CMS have, and if so, intend to use the authority to reduce Medicare Part B drug reimbursements?
- 3) Will CMS be monitoring access to care for Medicare beneficiaries once the sequester takes effect - particularly for services where interruption or delay could mean success or failure of treatment, such as cancer care? What steps has CMS taken to avoid negatively affecting Medicare beneficiaries receiving chemotherapy and other specialty infusible drugs?
- 4) Does CMS believe any flexibility exists to modify cuts in areas where access barriers become present?
- 5) How will CMS calculate the reduction required under the sequester? Will it apply to the entire payment for the drug (ASP+6%) or only the base ASP amount, or only to the +6%?
- 6) Has CMS reviewed the potential program costs and impact on Medicare beneficiaries that the reduction required by the sequester may cause? For example, will reduced access to cancer clinics cause beneficiaries to seek services in higher-cost sites of care?
- 7) Have you received or collected any information about Medicare beneficiaries, to date, being turned away from their healthcare provider due to uncertainty about the future reimbursement rates for their Part B drugs?

We ask that you answer the questions posed and if ultimately this cut is applied, use any and all flexibility available to you to ensure a potential sequester cut is applied to just the 6 percent service payment and not to the underlying fixed drug cost (ASP). We are asking, therefore, that any available flexibility be used to direct the cuts away from patients. Our hope is that there is a solution that protects patients' access to their healthcare professionals. We look forward to working with you to implement impending spending reductions in a way that does not threaten needed access to care for Medicare beneficiaries.

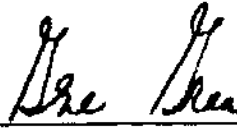
Thank you again for your attention to this important matter. In light of the sequester implementation on April 1, we kindly request that you provide a response to this letter on or before April 29, 2013.

Sincerely,

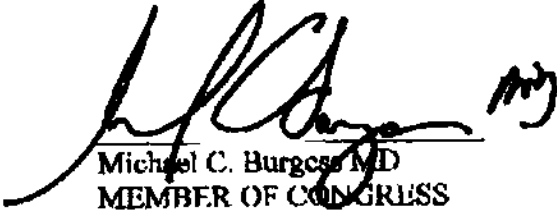
¹²¹ Sarah Kliff, "Cancer clinics are turning away thousands of Medicare patients. Blame the sequester," *The Washington Post's WonkBlog*, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/03/cancer-clinics-are-turning-away-thousands-of-medicare-patients-blame-the-sequester/>, April 3, 2013.



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Gene Green
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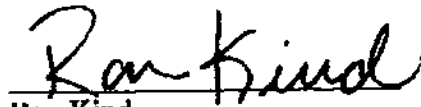
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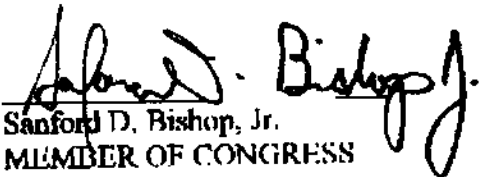
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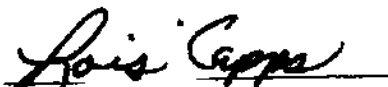
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G.K. Butterfield
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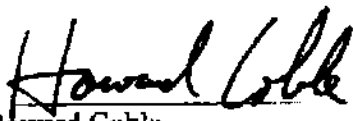

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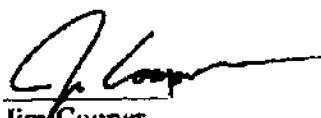

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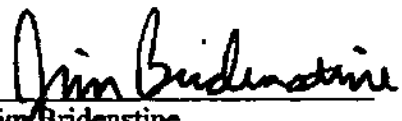

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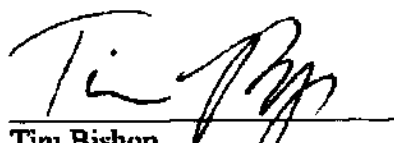

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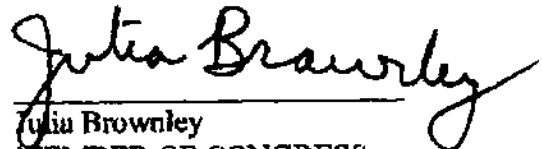

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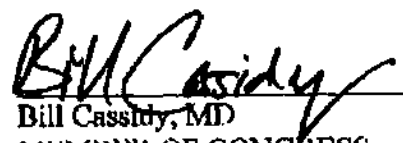

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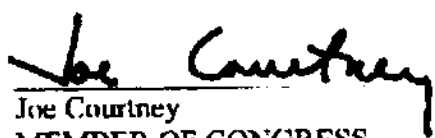

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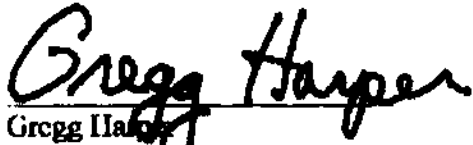
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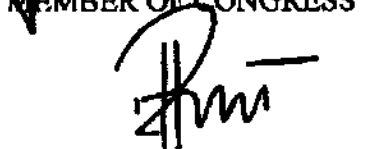
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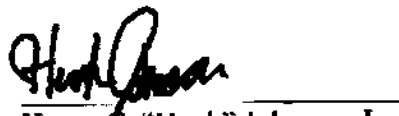

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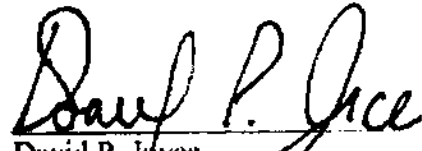

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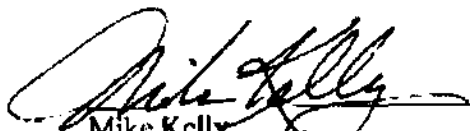

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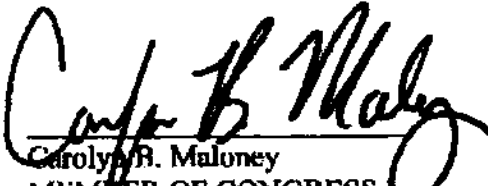

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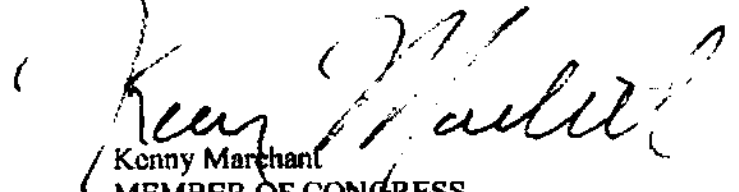

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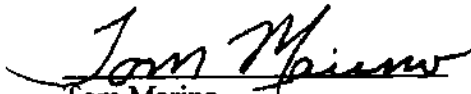

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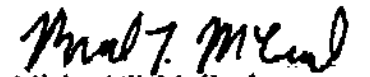

Carolyn B. Maloney
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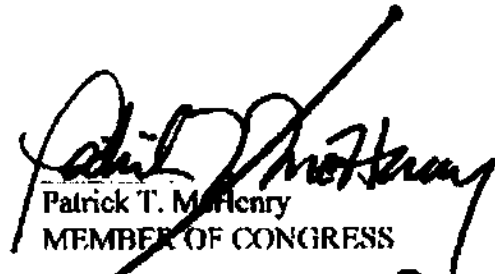

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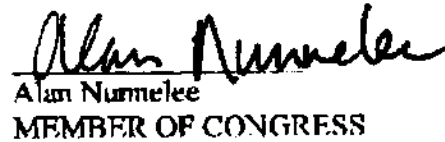

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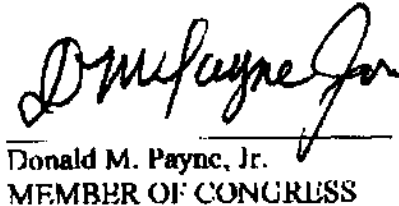

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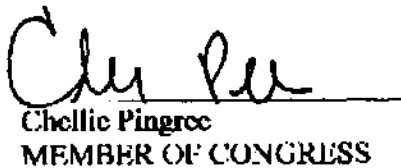

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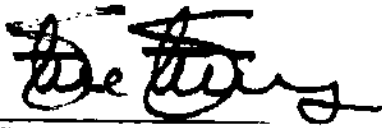

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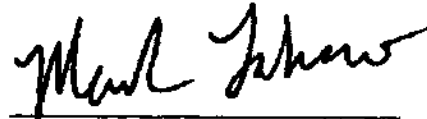
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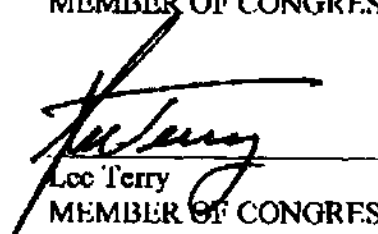
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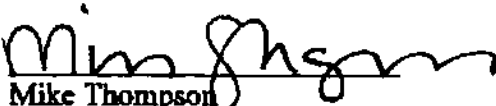
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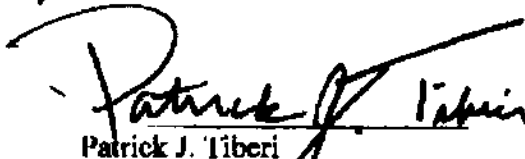
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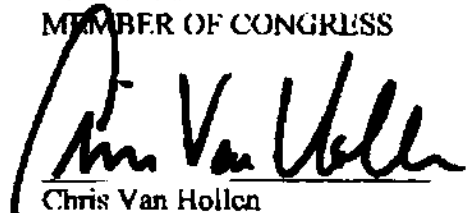
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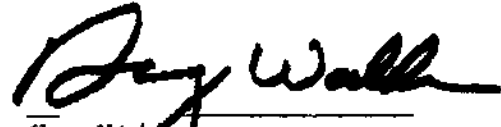
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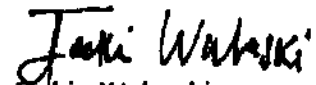
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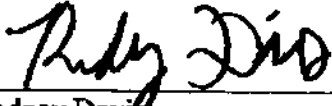
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JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification and the International Classification of Diseases, 10th Revision, Procedure Coding System (collectively, ICD-10). The Centers for Medicare & Medicaid Services (CMS) has made excellent progress on ICD-10 and we are on track to implement ICD-10 on October 1, 2015. CMS's Medicare Fee-For-Service (FFS) claims processing systems are ready for the compliance date of October 1, 2015. We will continue to test our systems with each quarterly release to ensure ICD-10 readiness. In April, we completed the second end-to-end testing week with providers – professional and hospitals, with another planned for later this summer. Extensive efforts are being made to reach out to providers to make sure they are ready. CMS has collaborated with physicians and other industry stakeholders to create tailored training and tools specifically to help physicians and their staff prepare for the ICD-10 transition.

Recognizing that health care providers need help with the transition, CMS and the American Medical Association are announcing efforts to continue to help physicians get ready ahead of the October 1 deadline. In response to requests from the provider community, CMS is releasing additional guidance below that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

- For 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015.
- For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used

a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes.

CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients if the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes).

- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.
- CMS will name an ICD-10 Ombudsman to help receive and triage physician and provider issues.

In your letter, you requested that we make public any contingency plan, for how Medicare will process claims in the event that CMS is unable to process ICD-10 diagnosis codes on October 1, 2015. We have developed a contingency plan which outlines the steps CMS will take to monitor, assess and address issues affecting Medicare FFS claims processing if they were to arise after the transition. The contingency plan is intended as an internal risk mitigation plan specifying CMS action should certain technical situations arise. The plan addresses the Agency's response in the following scenarios: if covered entities are unable to submit ICD-10 codes, if covered entities are submitting incorrect ICD-10 codes, and if CMS's Medicare FFS claims processing systems are unable to accept and correctly process claims. CMS has already publicly released in other formats the parts of the contingency plan relevant to providers, including claims submission alternatives. The following claims submission alternatives are available for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the physician be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every MAC;
- In about half of the MAC jurisdictions, providers can submit claims through a MAC provider internet portal; and
- Permitting small providers to submit paper claims if the requirements of section 1862(h) are met.

CMS is using every opportunity to help providers prepare for the ICD-10 transition and inform them of their options should they not be ready as of the mandated compliance date. If providers learn through testing that their systems will not be ready in time, we want them to know what their contingency options will be so that they can exercise the options early. CMS will continue to reinforce this information regularly as the compliance date draws near.

Additionally, you requested that we indicate whether claims must include the ICD-10 diagnosis code with the highest level of specificity immediately upon the October 1, 2015 effective date, or whether a clinically accurate but less granular code will be accepted. In addition to the audit flexibility regarding code specificity CMS just announced, CMS has issued guidance on the use of unspecified codes for Medicare FFS claims. In ICD-9-CM and ICD-10-CM, signs/symptoms and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when such codes most accurately reflect what is known.

You also asked that these efforts be incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities. In preparation for the ICD-10 transition, CMS has conducted a comprehensive analysis to ensure the Fraud Prevention System, as well as its underlying model and edit components, is equipped to mitigate any potential vulnerabilities that arise from or during the transition. As part of this analysis, CMS specifically:

- Reviewed each model and edit currently running in production to determine applicable ICD-10 impacts/updates;
- Reviewed all potential/scheduled models and edits to determine applicable ICD-10 impacts/updates; and
- Ensured any edits implemented after 6/1/15 included both ICD-9 and ICD-10 codes.

The ICD-10 impacts for existing edits will be updated prior to the transition this fall. While no other active edit has a diagnosis component, all future edits will cover both ICD-9 and ICD-10.

CMS has also researched several new models to identify outliers and prevent improper payments to use as a baseline for developing and updating future models. A multi-phased approach will be employed to carefully transition to ICD-10 claims analysis. As historic data accumulates, it will allow us to identify thresholds and create true predictive models.

As indicated above, CMS has worked to ensure our models and edits take into account any changes from ICD-9 to ICD-10. As the history of ICD-10 codes submitted evolves, CMS will continually update our models, edits, and analytic techniques. As is currently our practice, CMS will continue to engage teams of policy, subject matter, medical and analytic experts as indicated to address specific vulnerabilities.

Your letter also recommended that CMS expand its voluntary "end to end testing" beyond the current 2,500 providers. CMS is conducting an unprecedented level of testing to prepare

providers for ICD-10 and has instructed its MACs to reconfigure test environments specifically for ICD-10 to help support provider readiness. Two types of testing are available: acknowledgement testing that allows providers to test their ability to submit ICD-10 codes, and end-to-end testing that simulates full claims adjudication.

ICD-10 acknowledgement testing is available at any time to all electronic submitters through September 30, 2015. In addition, CMS has conducted four acknowledgement testing weeks in March 2014, November 2014, March 2015 and June 2015 to provide for additional submitter customer service and help desk support to help providers work through identified issues.

CMS is also conducting end-to-end testing with providers. The first two testing periods occurred in January and April 2015; the final end-to-end testing period occurs July 20-24. End-to-end testing differs from acknowledgement testing in that it involves the full claims adjudication cycle, and as such requires extensive time and resources up-front to prepare our systems and load appropriate claims history and demographics for the providers and beneficiaries used in testing. Testers are permitted to submit up to five National Provider Identifiers (NPIs) each and up to 50 claims. Between January and April, approximately 3,000 NPIs were registered to participate in end-to-end testing representing a broad-range of provider and claim types.

Overall, CMS believes this two-tiered external testing approach, in addition to extensive CMS internal testing, has been sufficient to broadly evaluate the ability of Medicare FFS systems to accommodate ICD-10 and appropriately adjudicate ICD-10 coded claims.

Additionally, you proposed that CMS promote awareness of resources such as Internet-based portals to submit claims with ICD-10 codes; and established regulatory processes that allow advanced or accelerated payments under certain circumstances. CMS has created tailored training, resources, and tools specifically to help physicians and their staffs prepare for the ICD-10 transition. CMS has developed multiple tools and resources that are available on the ICD-10 website (<http://www.cms.gov/ICD10>), including ICD-10 implementation guides, tools for small and rural providers, and general equivalency mappings (ICD-9 to ICD-10 crosswalk). We also have expanded our free training for providers across the country through national provider calls and webinars, training videos, and testing; and created tools and resources like the CMS website and Road to 10 Tool.

The Road to 10 Tool, for example, was created in collaboration with small physician practices and features five simple steps that physicians should take to prepare for ICD-10 with guided milestones and action plans. The Road to 10 highlights provider-inspired tip sheets, fact sheets, checklists, and free local training. The tool also features interactive clinical scenarios and case studies as well as coding and clinical documentation tips for both primary care and specialty training. CMS has also released provider training videos that offer helpful ICD-10 implementation tips with some providing free continuing medical education and continuing education credits. With extensive input from provider and industry stakeholders, CMS continues to develop new implementation and educational resources to help providers successfully transition to ICD-10.

CMS will be releasing additional educational products and revising existing products found at <http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html>. Included will be information about the claims submission alternatives available for providers who are unable to submit ICD-10 diagnosis codes due to problems with their billing systems.

CMS remains committed to the continuity of care for our beneficiaries and timely payments to Medicare providers, while we continue to safeguard trust fund dollars. CMS would consider the application of current published regulations, 42 CFR § 421.214(g), which provides that CMS may determine circumstances that warrant the issuance of advance payments to all affected suppliers furnishing Part B services without requiring specific requests from the physician/supplier. This authority applies only to the situation where CMS systems would be unable to process valid Part B claims that contain ICD-10 codes beginning October 1, 2015. If CMS were to rely upon this authority, then no further action would be needed by the physician/supplier.

Lastly, you advised CMS to coordinate with non-Medicare payers on the above activities to the extent feasible. Our ICD-10 work at CMS is part of the larger health care community's efforts to implement ICD-10. CMS continues to collaborate and partner with all industry stakeholders. The Agency hosts national weekly implementation meetings with provider groups, industry stakeholders, clearinghouses, vendors, and commercial payers. We have called for the healthcare industry at-large to align its outreach efforts to provide the necessary resources and guidance to help physicians make the transition to ICD-10.

There is a critical need to move from the over 35-year-old ICD-9 coding system to ICD-10. Dramatic advances in medicine have occurred, and ICD-9 codes are not specific enough to adequately capture diagnoses and services furnished. ICD-10 provides greater specificity to diagnosis-related groups and improves quality measurement and reporting capabilities needed for the Merit-based Incentive Payment System and the Alternative Payment Models as provided in the Medicare Access and CHIP Reauthorization Act of 2015. ICD-10's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, and research and data analysis. ICD-10 provides detailed data to inform health care delivery and health policy decisions.

The health care industry has invested significant resources toward the implementation of ICD-10. Many providers, including physicians, hospitals, and health plans, have already completed the necessary system changes to transition to ICD-10. Additional delays would pose significant costs for providers who have updated their systems. The 2014 final rule titled "Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets" and published on August 4, 2014 (79 FR 45128) estimated the costs of the recent one year ICD-10 delay at \$422 million to \$3.8 billion for hospitals and large providers and between \$547 million and \$2.7 billion for commercial health plans and third party administrators. Maintaining the current implementation date would spare these providers from incurring further costs.

Page 6 – The Honorable Kevin Brady

Thank you for your interest in this important topic. We look forward to working with Congress as we transition to ICD-10 on October 1, 2015. I will provide a copy of this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt". The signature is fluid and cursive, with a prominent initial "A" and a long, sweeping underline.

Andrew M. Slavitt
Acting Administrator



JUL - 6 2015

Administrator

Washington, DC 20201

The Honorable Sam Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

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Page 6 – The Honorable Sam Johnson

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JUL - 6 2015

Administrator
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The Honorable Devin Nunes
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JUL - 6 2015

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U.S. House of Representatives
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Page 6 – The Honorable Tom Price, M.D.

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Andrew M. Slavitt
Acting Administrator



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Patrick Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

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- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.
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CMS is using every opportunity to help providers prepare for the ICD-10 transition and inform them of their options should they not be ready as of the mandated compliance date. If providers learn through testing that their systems will not be ready in time, we want them to know what their contingency options will be so that they can exercise the options early. CMS will continue to reinforce this information regularly as the compliance date draws near.

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You also asked that these efforts be incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities. In preparation for the ICD-10 transition, CMS has conducted a comprehensive analysis to ensure the Fraud Prevention System, as well as its underlying model and edit components, is equipped to mitigate any potential vulnerabilities that arise from or during the transition. As part of this analysis, CMS specifically:

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As indicated above, CMS has worked to ensure our models and edits take into account any changes from ICD-9 to ICD-10. As the history of ICD-10 codes submitted evolves, CMS will continually update our models, edits, and analytic techniques. As is currently our practice, CMS will continue to engage teams of policy, subject matter, medical and analytic experts as indicated to address specific vulnerabilities.

Your letter also recommended that CMS expand its voluntary "end to end testing" beyond the current 2,500 providers. CMS is conducting an unprecedented level of testing to prepare

providers for ICD-10 and has instructed its MACs to reconfigure test environments specifically for ICD-10 to help support provider readiness. Two types of testing are available: acknowledgement testing that allows providers to test their ability to submit ICD-10 codes, and end-to-end testing that simulates full claims adjudication.

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Overall, CMS believes this two-tiered external testing approach, in addition to extensive CMS internal testing, has been sufficient to broadly evaluate the ability of Medicare FFS systems to accommodate ICD-10 and appropriately adjudicate ICD-10 coded claims.

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JUL - 6 2015

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The Honorable Vern Buchanan
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Page 6 – The Honorable Vern Buchanan

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Andrew M. Slavitt
Acting Administrator



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Adrian Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

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CMS remains committed to the continuity of care for our beneficiaries and timely payments to Medicare providers, while we continue to safeguard trust fund dollars. CMS would consider the application of current published regulations, 42 CFR § 421.214(g), which provides that CMS may determine circumstances that warrant the issuance of advance payments to all affected suppliers furnishing Part B services without requiring specific requests from the physician/supplier. This authority applies only to the situation where CMS systems would be unable to process valid Part B claims that contain ICD-10 codes beginning October 1, 2015. If CMS were to rely upon this authority, then no further action would be needed by the physician/supplier.

Lastly, you advised CMS to coordinate with non-Medicare payers on the above activities to the extent feasible. Our ICD-10 work at CMS is part of the larger health care community's efforts to implement ICD-10. CMS continues to collaborate and partner with all industry stakeholders. The Agency hosts national weekly implementation meetings with provider groups, industry stakeholders, clearinghouses, vendors, and commercial payers. We have called for the healthcare industry at-large to align its outreach efforts to provide the necessary resources and guidance to help physicians make the transition to ICD-10.

There is a critical need to move from the over 35-year-old ICD-9 coding system to ICD-10. Dramatic advances in medicine have occurred, and ICD-9 codes are not specific enough to adequately capture diagnoses and services furnished. ICD-10 provides greater specificity to diagnosis-related groups and improves quality measurement and reporting capabilities needed for the Merit-based Incentive Payment System and the Alternative Payment Models as provided in the Medicare Access and CHIP Reauthorization Act of 2015. ICD-10's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, and research and data analysis. ICD-10 provides detailed data to inform health care delivery and health policy decisions.

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Page 6 – The Honorable Adrian Smith

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Andrew M. Slavitt
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JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

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Page 6 -- The Honorable Lynn Jenkins

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JUL - 6 2015

Administrator
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The Honorable Diane Black
U.S. House of Representatives
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Page 6 – The Honorable Diane Black

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Andrew M. Slavitt
Acting Administrator



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515

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Your letter also recommended that CMS expand its voluntary "end to end testing" beyond the current 2,500 providers. CMS is conducting an unprecedented level of testing to prepare

providers for ICD-10 and has instructed its MACs to reconfigure test environments specifically for ICD-10 to help support provider readiness. Two types of testing are available: acknowledgement testing that allows providers to test their ability to submit ICD-10 codes, and end-to-end testing that simulates full claims adjudication.

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Page 6 – The Honorable Mike Kelly

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Acting Administrator



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Jim Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

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- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.
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CMS is using every opportunity to help providers prepare for the ICD-10 transition and inform them of their options should they not be ready as of the mandated compliance date. If providers learn through testing that their systems will not be ready in time, we want them to know what their contingency options will be so that they can exercise the options early. CMS will continue to reinforce this information regularly as the compliance date draws near.

Additionally, you requested that we indicate whether claims must include the ICD-10 diagnosis code with the highest level of specificity immediately upon the October 1, 2015 effective date, or whether a clinically accurate but less granular code will be accepted. In addition to the audit flexibility regarding code specificity CMS just announced, CMS has issued guidance on the use of unspecified codes for Medicare FFS claims. In ICD-9-CM and ICD-10-CM, signs/symptoms and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when such codes most accurately reflect what is known.

You also asked that these efforts be incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities. In preparation for the ICD-10 transition, CMS has conducted a comprehensive analysis to ensure the Fraud Prevention System, as well as its underlying model and edit components, is equipped to mitigate any potential vulnerabilities that arise from or during the transition. As part of this analysis, CMS specifically:

- Reviewed each model and edit currently running in production to determine applicable ICD-10 impacts/updates;
- Reviewed all potential/scheduled models and edits to determine applicable ICD-10 impacts/updates; and
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As indicated above, CMS has worked to ensure our models and edits take into account any changes from ICD-9 to ICD-10. As the history of ICD-10 codes submitted evolves, CMS will continually update our models, edits, and analytic techniques. As is currently our practice, CMS will continue to engage teams of policy, subject matter, medical and analytic experts as indicated to address specific vulnerabilities.

Your letter also recommended that CMS expand its voluntary "end to end testing" beyond the current 2,500 providers. CMS is conducting an unprecedented level of testing to prepare

providers for ICD-10 and has instructed its MACs to reconfigure test environments specifically for ICD-10 to help support provider readiness. Two types of testing are available: acknowledgement testing that allows providers to test their ability to submit ICD-10 codes, and end-to-end testing that simulates full claims adjudication.

ICD-10 acknowledgement testing is available at any time to all electronic submitters through September 30, 2015. In addition, CMS has conducted four acknowledgement testing weeks in March 2014, November 2014, March 2015 and June 2015 to provide for additional submitter customer service and help desk support to help providers work through identified issues.

CMS is also conducting end-to-end testing with providers. The first two testing periods occurred in January and April 2015; the final end-to-end testing period occurs July 20-24. End-to-end testing differs from acknowledgement testing in that it involves the full claims adjudication cycle, and as such requires extensive time and resources up-front to prepare our systems and load appropriate claims history and demographics for the providers and beneficiaries used in testing. Testers are permitted to submit up to five National Provider Identifiers (NPIs) each and up to 50 claims. Between January and April, approximately 3,000 NPIs were registered to participate in end-to-end testing representing a broad-range of provider and claim types.

Overall, CMS believes this two-tiered external testing approach, in addition to extensive CMS internal testing, has been sufficient to broadly evaluate the ability of Medicare FFS systems to accommodate ICD-10 and appropriately adjudicate ICD-10 coded claims.

Additionally, you proposed that CMS promote awareness of resources such as Internet-based portals to submit claims with ICD-10 codes; and established regulatory processes that allow advanced or accelerated payments under certain circumstances. CMS has created tailored training, resources, and tools specifically to help physicians and their staffs prepare for the ICD-10 transition. CMS has developed multiple tools and resources that are available on the ICD-10 website (<http://www.cms.gov/ICD10>), including ICD-10 implementation guides, tools for small and rural providers, and general equivalency mappings (ICD-9 to ICD-10 crosswalk). We also have expanded our free training for providers across the country through national provider calls and webinars, training videos, and testing; and created tools and resources like the CMS website and Road to 10 Tool.

The Road to 10 Tool, for example, was created in collaboration with small physician practices and features five simple steps that physicians should take to prepare for ICD-10 with guided milestones and action plans. The Road to 10 highlights provider-inspired tip sheets, fact sheets, checklists, and free local training. The tool also features interactive clinical scenarios and case studies as well as coding and clinical documentation tips for both primary care and specialty training. CMS has also released provider training videos that offer helpful ICD-10 implementation tips with some providing free continuing medical education and continuing education credits. With extensive input from provider and industry stakeholders, CMS continues to develop new implementation and educational resources to help providers successfully transition to ICD-10.

CMS will be releasing additional educational products and revising existing products found at <http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html>. Included will be information about the claims submission alternatives available for providers who are unable to submit ICD-10 diagnosis codes due to problems with their billing systems.

CMS remains committed to the continuity of care for our beneficiaries and timely payments to Medicare providers, while we continue to safeguard trust fund dollars. CMS would consider the application of current published regulations, 42 CFR § 421.214(g), which provides that CMS may determine circumstances that warrant the issuance of advance payments to all affected suppliers furnishing Part B services without requiring specific requests from the physician/supplier. This authority applies only to the situation where CMS systems would be unable to process valid Part B claims that contain ICD-10 codes beginning October 1, 2015. If CMS were to rely upon this authority, then no further action would be needed by the physician/supplier.

Lastly, you advised CMS to coordinate with non-Medicare payers on the above activities to the extent feasible. Our ICD-10 work at CMS is part of the larger health care community's efforts to implement ICD-10. CMS continues to collaborate and partner with all industry stakeholders. The Agency hosts national weekly implementation meetings with provider groups, industry stakeholders, clearinghouses, vendors, and commercial payers. We have called for the healthcare industry at-large to align its outreach efforts to provide the necessary resources and guidance to help physicians make the transition to ICD-10.

There is a critical need to move from the over 35-year-old ICD-9 coding system to ICD-10. Dramatic advances in medicine have occurred, and ICD-9 codes are not specific enough to adequately capture diagnoses and services furnished. ICD-10 provides greater specificity to diagnosis-related groups and improves quality measurement and reporting capabilities needed for the Merit-based Incentive Payment System and the Alternative Payment Models as provided in the Medicare Access and CHIP Reauthorization Act of 2015. ICD-10's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, and research and data analysis. ICD-10 provides detailed data to inform health care delivery and health policy decisions.

The health care industry has invested significant resources toward the implementation of ICD-10. Many providers, including physicians, hospitals, and health plans, have already completed the necessary system changes to transition to ICD-10. Additional delays would pose significant costs for providers who have updated their systems. The 2014 final rule titled "Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets" and published on August 4, 2014 (79 FR 45128) estimated the costs of the recent one year ICD-10 delay at \$422 million to \$3.8 billion for hospitals and large providers and between \$547 million and \$2.7 billion for commercial health plans and third party administrators. Maintaining the current implementation date would spare these providers from incurring further costs.

Page 6 – The Honorable Jim Renacci

Thank you for your interest in this important topic. We look forward to working with Congress as we transition to ICD-10 on October 1, 2015. I will provide a copy of this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt". The signature is fluid and cursive, with a prominent initial "A" and a long, sweeping underline.

Andrew M. Slavitt
Acting Administrator



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Kristi Noem
U.S. House of Representatives
Washington, DC 20515

Dear Representative Noem:

Thank you for your letter regarding the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification and the International Classification of Diseases, 10th Revision, Procedure Coding System (collectively, ICD-10). The Centers for Medicare & Medicaid Services (CMS) has made excellent progress on ICD-10 and we are on track to implement ICD-10 on October 1, 2015. CMS's Medicare Fee-For-Service (FFS) claims processing systems are ready for the compliance date of October 1, 2015. We will continue to test our systems with each quarterly release to ensure ICD-10 readiness. In April, we completed the second end-to-end testing week with providers – professional and hospitals, with another planned for later this summer. Extensive efforts are being made to reach out to providers to make sure they are ready. CMS has collaborated with physicians and other industry stakeholders to create tailored training and tools specifically to help physicians and their staff prepare for the ICD-10 transition.

Recognizing that health care providers need help with the transition, CMS and the American Medical Association are announcing efforts to continue to help physicians get ready ahead of the October 1 deadline. In response to requests from the provider community, CMS is releasing additional guidance below that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

- For 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015.
- For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used

a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes.

CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients if the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes).

- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.
- CMS will name an ICD-10 Ombudsman to help receive and triage physician and provider issues.

In your letter, you requested that we make public any contingency plan, for how Medicare will process claims in the event that CMS is unable to process ICD-10 diagnosis codes on October 1, 2015. We have developed a contingency plan which outlines the steps CMS will take to monitor, assess and address issues affecting Medicare FFS claims processing if they were to arise after the transition. The contingency plan is intended as an internal risk mitigation plan specifying CMS action should certain technical situations arise. The plan addresses the Agency's response in the following scenarios: if covered entities are unable to submit ICD-10 codes, if covered entities are submitting incorrect ICD-10 codes, and if CMS's Medicare FFS claims processing systems are unable to accept and correctly process claims. CMS has already publicly released in other formats the parts of the contingency plan relevant to providers, including claims submission alternatives. The following claims submission alternatives are available for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the physician be able to code in ICD-10:

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You also asked that these efforts be incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities. In preparation for the ICD-10 transition, CMS has conducted a comprehensive analysis to ensure the Fraud Prevention System, as well as its underlying model and edit components, is equipped to mitigate any potential vulnerabilities that arise from or during the transition. As part of this analysis, CMS specifically:

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Page 6 -- The Honorable Kristi Noem

Thank you for your interest in this important topic. We look forward to working with Congress as we transition to ICD-10 on October 1, 2015. I will provide a copy of this response to the co-signers of your letter.

Sincerely,

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Andrew M. Slavitt
Acting Administrator



CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.

KEVIN BRADY
MEMBER OF CONGRESS
8TH DISTRICT OF TEXAS

DEPUTY WHIP

COMMITTEE ON
WAYS AND MEANS
CHAIRMAN, SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON TRADE

JOINT ECONOMIC COMMITTEE
VICE CHAIRMAN

JOINT COMMITTEE ON TAXATION

June 01, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 314G
Washington, DC 20201

Dear Acting Administrator Slavitt:

As the deadline for implementation of the 10th revision of the International Classification of Diseases, Clinical Modification (ICD-10) codes quickly approaches we, the undersigned, request that the Centers for Medicare and Medicaid Services (CMS) take steps to instill confidence—especially among physicians—that the October 1, 2015 ICD-10 diagnosis code implementation will not cause widespread disruption. With the healthcare.gov debacle a vivid reminder of how technologically complex projects can go wrong despite agency assurances, we urge the agency to make information available to providers and the broader public that helps to address concerns. Accordingly, we recommend that CMS take the steps described below.

1. Make public any contingency plan, for how Medicare will process claims in the event that CMS is unable to process ICD-10 diagnosis codes on October 1, 2015. Providers need to know that they will receive timely payment for the services they furnish to seniors in the event that CMS systems fail to work as intended.
2. Indicate whether claims must include the ICD-10 diagnosis code with the highest level of specificity immediately upon the October 1, 2015 effective date, or whether a clinically accurate but less granular code will be accepted. A period during which less specific codes are accepted while providers get accustomed to the new system would be appropriate.
3. Make public a description of how ICD-10 diagnosis codes will be:
 - A. Applied to incentive payment programs for reporting on quality of care and other metrics, including how any anticipated increase in provider requests for incentive program

redeterminations will be handled; and

B. Incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities.

4. Expand its voluntary "end to end testing" beyond the current 2,500 providers. Testing with a robust, sample that includes the different providers and the different types of claims is critical to demonstrating readiness. Providers that want to test in a simulated "live" claims processing environment should have the opportunity to the extent feasible. Emphasis should be placed on small providers, especially physicians in small practice.


5. Educate providers on resources available to avoid claims processing disruption if CMS can accept but they are unable to submit ICD-10 diagnosis codes. Providers need to be aware that fallback options are available if they experience problems with their billing systems. CMS should promote awareness of resources such as internet-based portals to submit claims with ICD-10 codes; and established regulatory processes that allow advanced or accelerated payments under certain circumstances.

6. Coordinate with non-Medicare payers on the above activities to the extent feasible.

ICD-10 implementation is a significant undertaking. CMS needs to use the tools at its disposal to ensure a smooth transition to the new coding system. Using those tools in a transparent manner will help to avoid provider cash flow problems that could lead to patient care disruptions.

We look forward to your timely response regarding the above recommendations.

Sincerely,



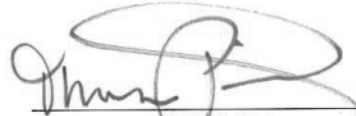
KEVIN BRADY
Chairman
Subcommittee on Health
Committee on Ways and Means



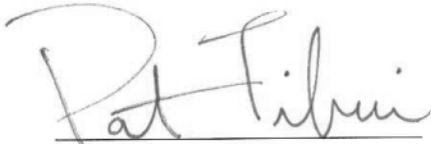
SAM JOHNSON
U.S. House of Representatives



DEVIN NUNES
U.S. House of Representatives



TOM PRICE, M.D.
U.S. House of Representatives




PATRICK TIBERI
U.S. House of Representatives



VERN BUCHANAN
U.S. House of Representatives



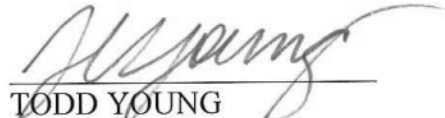
ADRIAN SMITH
U.S. House of Representatives



LYNN JENKINS
U.S. House of Representatives



DIANE BLACK
U.S. House of Representatives



TODD YOUNG
U.S. House of Representatives



MIKE KELLY
U.S. House of Representatives



JIM RENACCI
U.S. House of Representatives



KRISTI NOEM
U.S. House of Representatives



AUG - 2 2016

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter and sharing your concerns about step therapy. The Centers for Medicare & Medicaid Services (CMS) remains committed to Medicare and Medicaid beneficiaries' continued access to needed prescribed medications – a commitment that is also shared among the states. The purpose of this letter is to explain the application of step therapy within the Medicare Part D program and to describe federal requirements related to state Medicaid prior authorization programs, including step therapy protocols.

A Part D plan sponsor's Pharmacy & Therapeutics (P&T) committee must review for clinical appropriateness the practices and policies for formulary management activities, including step therapies. Formulary management decisions must be based on scientific evidence and may also be based on pharmacoeconomic considerations that achieve appropriate, safe and cost effective drug therapy. CMS reviews each Part D plan's benefit annually, including step therapy protocols. In addition, step therapy protocols are reviewed throughout the plan year should any updates occur. These reviews validate that each plan offers robust access to medications across drug categories and classes. If necessary, an enrollee, an enrollee's prescriber or an enrollee's representative may request a formulary exception to obtain a Part D drug that is subject to a utilization management restriction, such as step therapy, that the enrollee or enrollee's prescriber believes should not apply.

Coverage of prescription drugs is an optional benefit in state Medicaid programs, though all fifty states and the District of Columbia currently provide this benefit. These states have entered into and have in effect rebate agreements; therefore, these states are required to comply with the requirements of section 1927(d) of the Social Security Act (the Act). While states have the discretion to establish certain limitations on the coverage of these drugs – such as preferred drug lists and use of prior authorization processes, including step therapy – such practices must be consistent with requirements of section 1927(d) of the Act to ensure appropriate utilization.

The CMS encourages states to exercise sound clinical judgment and utilize available resources to determine their prescription drug coverage policies. These resources include P&T committees, drug utilization review (DUR) boards and comparative analysis of the costs to treat patients in light of the efficacy. On an annual basis, states are also required to report on their state's prescribing habits, cost savings generated from their DUR programs and their program's operations, including adoption of new innovative DUR practices through the Medicaid Drug Utilization Review Annual Report Survey. To access the FFY 2014 Annual DUR report, please visit <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/downloads/2014-dur-summary-report.pdf>.

Page 2 - The Honorable Tom Price

I hope you find the information and clarification provided within this letter useful in administering step therapy protocols. If you have any questions regarding this information, please contact the CMS Office of Legislation at 202-690-8220. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

June 8, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W. Washington, D.C. 20201

Dear Acting Administrator Slavitt:

The use of step therapy is common and growing among private and public payers. In 2013, 67 percent of employer sponsored health insurance plans reported that they had implemented step therapy policies, an increase from 27 percent in 2005. While we recognize that step therapy has at times been an effective practice that helps control costs throughout the healthcare sector, we want to ensure that the practice is not being used at the expense of patient health and well-being.

In some instances, step therapy protocols may provide appropriate and affordable drug treatments, however, in some cases it could have the opposite effect. Prolonging ineffective treatment and preventing patients from starting treatments recommended by their physician or health care provider in a timely manner can lead to poorer health outcomes and increased costs for patients and the health care system.

Too often, Federal policy focuses on short-term savings instead of long-term costs. The same is true of the healthcare system: early investments in preserving health can lower the long-term costs—especially for patients dealing with chronic diseases like rheumatoid arthritis, psoriatic arthritis, multiple sclerosis, diabetes, inflammatory bowel disease, cancer and mental health, among others. In a study comparing spending on schizophrenia medications in Georgia's Medicaid program, step therapy saved the state \$19.62 per member per month in pharmacy spending but these savings were accompanied by a \$31.59 per member per month increase in expenditures for outpatient costs.¹ When patients receive the right medicine at the right time, as determined by their physician, there are reduced complications, fewer follow up visits, and potentially greater savings to the healthcare system.

When implemented appropriately, step therapy can be an effective tool to ensure patients receive cost effective care. However, we should ensure that physicians have the ability to prescribe what they believe to be the most appropriate and effective medicine for each patient. Under your authority to oversee the Medicare program, we ask that you work to ensure that step therapy

protocols are open and transparent, do not create a barrier to access, and do not take prescribing power out of the hands of physicians.

Sincerely,



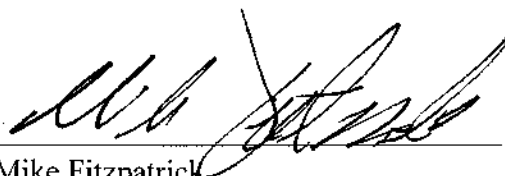
Leonard Lance
Member of Congress



Scott Peters
Member of Congress



Dan Benishek, M.D.
Member of Congress



Mike Fitzpatrick
Member of Congress



Mike Coffman
Member of Congress



Emanuel Cleaver
Member of Congress



H. Morgan Griffith
Member of Congress



Peter King
Member of Congress



Tom Price, M.D.
Member of Congress



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Ron Klein
House of Representatives
Washington, DC 20515

Dear Representative Klein:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.


Because the ASC payment system is budget neutral, there is no annual increase in total payments under this system unless the ASC payments are updated by the percentage increase in the CPI-U, which, as discussed above, Congress set at zero percent for CYs 2008 and 2009. The law did not prohibit annual increases for payment to hospital outpatient departments during this same time period, so we continued to update the payment rates for hospital outpatient services by the hospital inpatient market basket percentage increase. Therefore, differences in Medicare payments to ASCs and hospital outpatient departments since the revised payment system went into effect in CY 2008 can be attributed to the zero percent increase in the CPI-U for CYs 2008 and 2009.

The CY 2011 outpatient prospective payment system proposed rule was recently published in the *Federal Register* for public comment. The public comment period ends on August 31. For the reasons specified above, we are continuing to use the CPI-U to update ASC rates for 2011. In addition, the Affordable Care Act requires the annual update factor for the ASC payment system be reduced by a productivity adjustment factor. Final figures on both the CPI-U and the productivity adjustment factor will be included in the final rule that will be available no later than November 1.

Page 2 – The Honorable Ron Klein

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner". The signature is fluid and cursive, with a prominent loop at the end of the last name.

Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Kendrick B. Meek
House of Representatives
Washington, DC 20515

Dear Representative Meek:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.

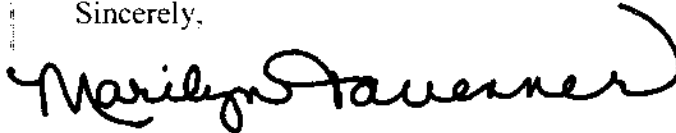
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Page 2 – The Honorable Kendrick B. Meek

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Suzanne M. Kosmas
House of Representatives
Washington, DC 20515

Dear Representative Kosmas:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.


Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.

Because the ASC payment system is budget neutral, there is no annual increase in total payments under this system unless the ASC payments are updated by the percentage increase in the CPI-U, which, as discussed above, Congress set at zero percent for CYs 2008 and 2009. The law did not prohibit annual increases for payment to hospital outpatient departments during this same time period, so we continued to update the payment rates for hospital outpatient services by the hospital inpatient market basket percentage increase. Therefore, differences in Medicare payments to ASCs and hospital outpatient departments since the revised payment system went into effect in CY 2008 can be attributed to the zero percent increase in the CPI-U for CYs 2008 and 2009.

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Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Alan Grayson
House of Representatives
Washington, DC 20515

Dear Representative Grayson:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

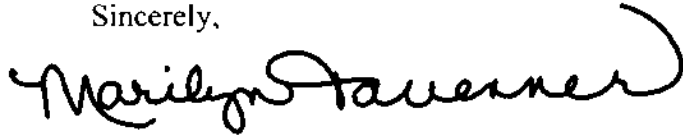
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Because the ASC payment system is budget neutral, there is no annual increase in total payments under this system unless the ASC payments are updated by the percentage increase in the CPI-U, which, as discussed above, Congress set at zero percent for CYs 2008 and 2009. The law did not prohibit annual increases for payment to hospital outpatient departments during this same time period, so we continued to update the payment rates for hospital outpatient services by the hospital inpatient market basket percentage increase. Therefore, differences in Medicare payments to ASCs and hospital outpatient departments since the revised payment system went into effect in CY 2008 can be attributed to the zero percent increase in the CPI-U for CYs 2008 and 2009.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Jerry McNerney
House of Representatives
Washington, DC 20515

Dear Representative McNerney:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

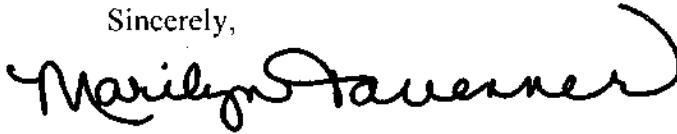
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Bill Cassidy
House of Representatives
Washington, DC 20515

Dear Representative Cassidy:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update.

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Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update.

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Page 2 - The Honorable Tom Price

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Pete Sessions
House of Representatives
Washington, DC 20515

Dear Representative Sessions:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Marsha Blackburn
House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

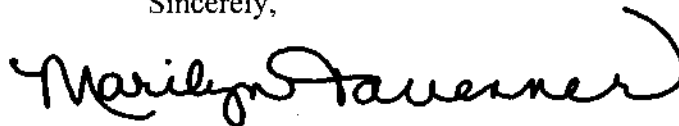
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Todd Russell Platts
House of Representatives
Washington, DC 20515

Dear Representative Platts:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

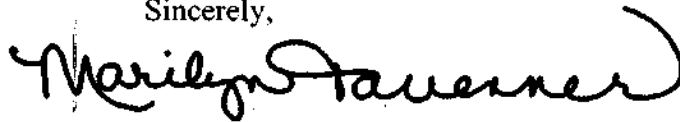
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Corrine Brown
House of Representatives
Washington, DC 20515

Dear Representative Brown:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

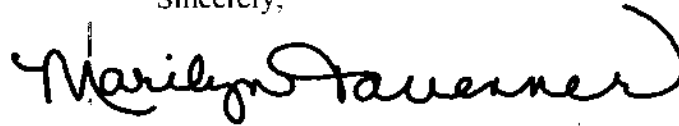
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner". The signature is written in black ink and is positioned above the printed name and title.

Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Shelley Berkley
House of Representatives
Washington, DC 20515

Dear Representative Berkley:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

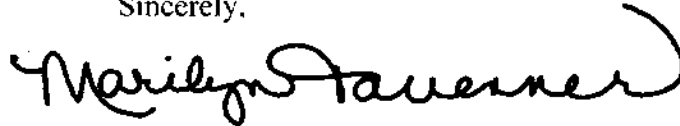
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable David Wu
House of Representatives
Washington, DC 20515

Dear Representative Wu:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

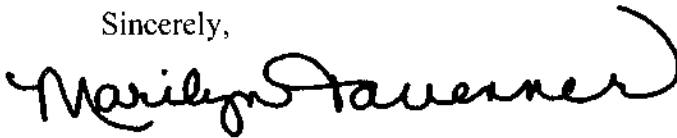
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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

*Deputy Administrator*

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Barney Frank
House of Representatives
Washington, DC 20515

Dear Representative Frank:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update.

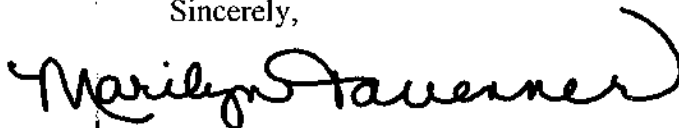
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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Adam Smith
House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

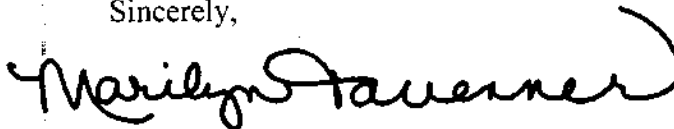
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Sincerely,

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable John B. Larson
House of Representatives
Washington, DC 20515

Dear Representative Larson:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Charlie Melancon
House of Representatives
Washington, DC 20515

Dear Representative Melancon:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update.

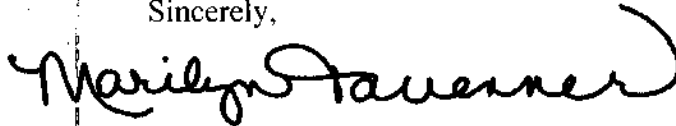
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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Dina Titus
House of Representatives
Washington, DC 20515

Dear Representative Titus:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update. Additionally, for calendar years (CYs) 2008 and 2009, Congress mandated in section 1833(i)(2)(C)(iv) of the Act that the CPI-U increase be zero percent. In view of this statutory language, CMS adopted a final policy to use the CPI-U to update the ASC payment amounts for CY 2010 and subsequent years in the final rule implementing the revised ASC payment system.

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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Jim McDermott
House of Representatives
Washington, DC 20515

Dear Representative McDermott:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

Section 1833(i)(2)(C) of the Social Security Act (the Act) requires that payment amounts established under the revised payment system for ASCs be increased by the percentage increase in the consumer price index for urban consumers (CPI-U), if the Secretary has not otherwise updated such amounts for that year. Congress established the CPI-U as the default update for the ASC payment system in the absence of any other update.

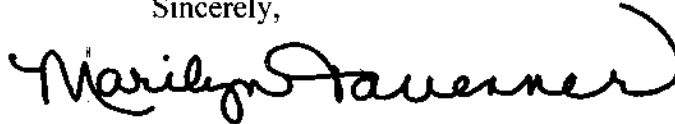
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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer



Deputy Administrator

Baltimore, MD 21244-1850

JUL 15 2010

The Honorable Joseph R. Pitts
House of Representatives
Washington, DC 20515

Dear Representative Pitts:

Thank you for your letter regarding updates to the Medicare ambulatory surgical center (ASC) payment system. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

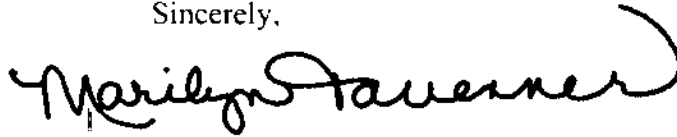
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Marilyn Tavenner
Principal Deputy Administrator and
Chief Operating Officer

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Correspondence Cover Sheet

Doc ID: **062420104018** *Date Due:*

Corr. From: **Ron Klein, et al.** *Task Date:*

On Behalf Of:

Letter Date: **6/21/2010** *Folder Created:* **6/24/2010**

Subject: **32 Cong. Dele. /Medicare Payments to Ambulatory Surgical Centers (ASCs).**

Synopsis: **32 Cong. Dele. /Medicare Payments to Ambulatory Surgical Centers (ASCs).**

Primary Issues: **Access to Services**

Program Office Assigned:

Action Required: **Prep for Sig** *Signature Level:* **Admin Sig**

Coordinator: **Cynthia Dickerson** *Data Entry By:* **Brenda McCray**

Instructions: None

Please send your responses to the assigning office.

Congress of the United States
Washington, DC 20515

Comm

June 21, 2010

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Tavenner:

We are writing to request your assistance in addressing declining Medicare payments to ambulatory surgical centers (ASCs). In light of the recent enactment of the Patient Protection and Affordable Care Act (P.L. 111-148), Medicare will now more than ever be seeking to facilitate the delivery of health care services in the most cost-effective manner. To further this objective, we ask the Centers for Medicare and Medicaid Services (CMS) to use its existing discretionary authority to make an important modification to the ASC payment system – update ASC payments using the hospital market basket index rather than the current consumer price index for urban consumers (CPI-U).

The use of the CPI-U as the basis for Medicare's annual updates to ASC payments encompasses two problems:

First, the CPI-U is an inappropriate index upon which to rely for the purpose of updating ASC payment rates. The CPI-U is a widely used measure of price inflation that is based on a sample of prices on a broad mix of goods and services, such as food and apparel. In its March 2010 report to Congress, the Medicare Payment Advisory Commission stated its concern that CPI-U may not reflect ASC cost structures and, therefore, the use of CPI-U may not be a reasonable proxy to measure changes in ASC costs, such as medical equipment and supplies, clinical staff, and malpractice insurance.

Second, the CPI-U as the annual ASC inflator is a significant contributing factor to the growing gap between ASC and hospital outpatient department (HOPD) payment rates. This divergence in rates occurs because hospital payments are updated on the basis of the hospital market basket, an index that is historically higher than the CPI-U. For example, the most recently published measure of the CPI-U for 2011 is 1.4 percent, while, comparatively, the latest forecast for the hospital market basket is 2.4 percent.

In 2008, 3.3 million Medicare beneficiaries requiring outpatient surgical services, including screening services, received those services in ASCs. Medicare beneficiaries choose to receive

Congressional Letter to CMS for ASCs P. 2

surgical services in ASCs because they are convenient and safe, offer high-quality services with significantly lower cost sharing, and often allow a patient to receive services from a physician with whom he/she has an established relationship.

Of equal importance, we believe that the growing disparity between ASC payments and HOPD rates will result in the migration of surgical services currently provided in ASCs back to hospitals at greater cost to the Medicare program and to beneficiaries. If half of all eligible outpatient procedures were shifted from the HOPD to ASCs, it would save Medicare about \$2 billion per year. Additionally, ASCs are small businesses that provide valuable services to our constituencies and employ health care professionals in our communities. For any business to survive, reimbursement must be at least commensurate with costs.

We believe that the use of the hospital market basket to update ASC payments offers the benefit of more closely aligning the ASC payment system with the hospital outpatient prospective payment system as was intended when the ASC payment system underwent substantial change in 2008. Accordingly, we hope that you will accept our recommendation and act accordingly to implement the hospital market basket as the inflation index for ASCs beginning in 2011. Thank you for your consideration of our request.

Sincerely,

① *Ron Klein*
Ron Klein
Member of Congress

⑥ *Bill Cassidy*
Bill Cassidy
Member of Congress

② *Kendrick B. Meek*
Kendrick B. Meek
Member of Congress

⑦ *Tom Price*
Tom Price
Member of Congress

③ *Suzanne M. Kosmas*
Suzanne M. Kosmas
Member of Congress

⑧ *Pete Sessions*
Pete Sessions
Member of Congress

④ *Alan Grayson*
Alan Grayson
Member of Congress

⑨ *Marsha Blackburn*
Marsha Blackburn
Member of Congress

⑤ *Jerry McNerney*
Jerry McNerney
Member of Congress

⑩ *Todd Russell Platts*
Todd Russell Platts
Member of Congress

Congressional Letter to CMS for ASCs P. 3

- 11 *Corrine Brown*
 Corrine Brown
 Member of Congress
- 12 *Shelley Berkley*
 Shelley Berkley
 Member of Congress
- 13 *David Wu*
 David Wu
 Member of Congress
- 14 *Barney Frank*
 Barney Frank
 Member of Congress
- 15 *Adam Smith*
 Adam Smith
 Member of Congress
- 16 *John B. Larson*
 John B. Larson
 Member of Congress
- 17 *Charlie Melancon*
 Charlie Melancon
 Member of Congress
- 18 *Dina Titus*
 Dina Titus
 Member of Congress
- 19 *Jim McDermott*
 Jim McDermott
 Member of Congress
- 20 *Joseph R. Pitts*
 Joseph R. Pitts
 Member of Congress
- 21 *Michael C. Burgess*
 Michael C. Burgess
 Member of Congress
- 22 *Sam Johnson*
 Sam Johnson
 Member of Congress
- 23 *Ralph M. Hall*
 Ralph M. Hall
 Member of Congress
- 24 *Rodney Alexander*
 Rodney Alexander
 Member of Congress
- 25 *Jo Bonner*
 Jo Bonner
 Member of Congress
- 26 *Kenny Marchant*
 Kenny Marchant
 Member of Congress
- 27 *John Shimkus*
 John Shimkus
 Member of Congress
- 28 *Randy Neugebauer*
 Randy Neugebauer
 Member of Congress

Congressional Letter to CMS for ASCs P. 4

29 *Danny K. Davis* 31

Danny K. Davis
Member of Congress

Doug Lamborn

Doug Lamborn
Member of Congress

30 *Rick Larsen*

Rick Larsen
Member of Congress

32 *Cathy McMorris Rodgers*

Cathy McMorris Rodgers
Member of Congress

32 Cong. Dele.



SEP 20 2011

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter expressing concerns about a payment change that was initially discussed in the Skilled Nursing Facility (SNF) Prospective Payment System proposed rule for fiscal year (FY) 2012, and subsequently finalized on July 29, 2011. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The payment change you note involves a recalibration of a previous payment adjustment made in FY 2011 that was intended to ensure that the transition from an earlier case-mix classification system, Version 3 of the Resource Utilization Groups (RUG-III), to the current Version 4 (RUG-IV), was made in a budget neutral manner. However, this payment adjustment instead triggered a significant, unintended spike in payments. This increase in spending was primarily due to shifts in utilization of therapy modes under the new classification system, differing significantly from the projections on which the previous payment adjustment was based.

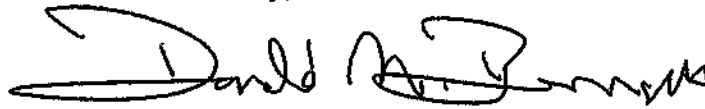
We agree that it would not be appropriate to undertake this type of adjustment based on insufficient or inaccurate data. Although the initial analysis in the proposed rule used one quarter of FY 2011 claims data, we subsequently acquired additional data for the final rule that enabled us to reassess the proposed recalibration using 8 months of data. Not only did these additional data confirm our initial findings of significant excess payments during FY 2011, but our findings have also been supported by a study recently conducted by the Office of the Inspector General (OIG) entitled "Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011" (OEI-02-09-00204, available online at <http://oig.hhs.gov/oei/reports/oei-02-09-00204.asp>). The OIG study found that the utilization trends underlying the excess payments, i.e., shifts in therapy modes, are shown to be even more pronounced in the recent data.

CMS considered the concerns you raise and similar public comments regarding the potential adverse effects of the recalibration on patients and providers. These comments also included suggestions that we should consider phasing in the recalibration over multiple years to mitigate such effects. We finalized the recalibration in the FY 2012 final rule that appeared in the August 8, 2011, *Federal Register*. The recalibration will result in a reduction of 12.6 percent in SNF payments (which will be partly offset by the FY 2012 market basket update of 1.7 percent). We noted in the final rule that implementing the recalibration over multiple years would continue Medicare payments in amounts that significantly exceed the intended and appropriate level. The recalibration serves to remove a short-term, unintended spike in payments that occurred in one

year rather than decreasing an otherwise appropriate payment amount. After applying the recalibration, the FY 2012 payment rates still represent an actual increase of 3.4 percent over the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels. Thus, the FY 2012 payment rates represent a “reduction” *only* in relation to the payment rates for FY 2011, which were themselves aberrantly high. In addition, we are not recouping retroactively the excess expenditures already made to SNFs during FY 2011. Accordingly, we do not believe that the recalibration should negatively affect the quality of care for patients, or create an undue hardship on providers. However, we will be closely monitoring payments in FY 2012 to ensure that they are appropriate and continue to support high quality care.

Thank you again for your letter on the FY 2012 SNF payment rule. I appreciate your raising this concern on this important matter, and look forward to continuing to work with you on our mutual goal of strengthening the Medicare program for all beneficiaries.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick". The signature is fluid and cursive, with a large initial "D" and "B".

Donald M. Berwick, M.D.



Congress of the United States
House of Representatives
Washington, DC 20515

June 24, 2011

Administrator Donald Berwick
 Centers for Medicare & Medicaid Services
 Department of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

062820114005
RECEIVED
 JUN 28 2011
 OSORA, DIVISION
 OF CORRESPONDENCE MANAGEMENT
 Due: 7.13.11

Dear Dr. Berwick:

We are writing to express our concern over deep Medicare payment cuts proposed by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facilities (SNFs). The cuts, which would reduce Medicare reimbursement for SNFs immediately by 12.8 percent, are included as one option that the agency is considering as part of its Fiscal Year 2012 Medicare payment policy for SNFs.

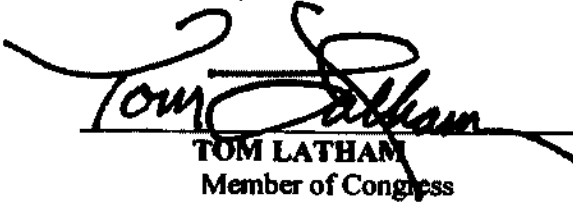
Skilled nursing facilities provide critical health care services for our nation's senior citizens. Over 1.7 million Medicare beneficiaries receive long-term and post-acute care services each year in nursing homes. CMS has a responsibility to ensure that Medicare payment policies for these facilities are supported by accurate data and implemented fairly in order to protect these vulnerable Medicare patients.

It is our understanding that the option for a 12.8 percent payment cut was put forward by CMS in order to account for a potential error the agency believes may have occurred when it implemented changes to the Medicare payment system for SNFs last year. However, CMS has based this option on data obtained from only one fiscal quarter, which we believe is unprecedented. Given the limited timeframe, we are concerned that the agency's proposed option is not based upon accurate data.

Financial stability is critical to ensuring sustainable, quality long-term care for Medicare beneficiaries in nursing facilities. The men and women who work in these facilities, approximately 3.1 million Americans, are responsible for serving some of the frailest members of our society. We must ensure that the services they provide to Medicare beneficiaries are preserved.

On behalf of our constituents who receive care in SNFs, we request the agency take a more measured approach and delay any proposed cuts pending a review of data from a full year. If, after reviewing additional data, CMS ultimately determines that comprehensive information supports the need to adjust payments to SNFs, then it should follow its common practice of implementing the reduction over a period of two or three years in order to reduce the potential impact on nursing facility services.

We appreciate your consideration of these concerns.


TOM LATHAM
 Member of Congress


RICHARD E. NEAL
 Member of Congress

CC: President Obama, Health and Human Services Secretary Kathleen Sebelius

Hank Johnson

Michael E. Capuano

Ron Kind

Joe Donnelly

Dave Luntak

Richard B. Aycock

Deirdre F. Caldwell

Larry Kinell

Nikki Bongas

Mel Bongas

Bill Shust

Grace S. Napolitano

Bob McElm

Tom J. Walsh

Michael H. Merchant

Bruce Bradley

Jim Langwin

Subal Brany

Pat Tibben

J. Hume

Tim Huebner

Kathy Caste

Howard Dorell

To Bonner

Barbara Lee

Jim Stoen

Pat Tang

Jenny Baldwin

Leonard L Bonnell

Steve King

Lyons Jenkins

Nam P O'Leary

Tim Griffin (AR-02)

Ch Brantley

Benny Frank

Bl Goulette

Denny H. Cain

Howard Eoble

Dry Walden

Chas W Dent

John W. Oliver

Jaine Herrera Butler

Allyson J Schwartz

Charles A. Spaly

Alan Amundson

Rosa DeLuca

Tom Holden

Cathy McNamee Rodgers

Samuel D. McHugh Jr.

Jim Mathews

~~Don~~

A. Ruth Ruppberg

Tom Peter

Mike Cahill

Pete Sessa

Lois Capps

Mike Row

Di. Oley

J. Rudy Horke

Steven Nothman

Bill Pasarell

E. Whitfield

Charles B. Rangel

John Bannor

F. Puum

Edith E. Turnings

Jean Atmire

Shelley Berkeley

Bill Owens

Stea Seabro

Herman Gold NCG

Jean Schmidt Oh-2

Raymond TX 18

[Signature]

J. H. C.

Dorothy Thompson PA-5

Marsina Blackburn

Mike Doyle

John [Signature]

Joseph Pitts

John Henry 18904

[Signature]

Paul [Signature]

[Signature]

Mark Stempson

[Signature]

Joe Courtney

Bert Bathurst

Frederica S. Wilson

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Tim Murray

Rodney Alexander

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Jim McPhee

Leonard Lence

John F. Tamm

Ed Parker

Charles Bass

Frank Palmer Jr.

Vern Buchanan

William B. Keating

Greg Harper

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Ben Long

Tom Marino

Atvaria

Dilly Long

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Howard P. Bunn

Shelley Moore Capito

David B. Bonior

W. F. T. V

John Campbell

John (11-19)

Donald A. Mangum

Jeff Miller

N. Morgan Tuffin

Na Haywood

Kevin Under

Stephen L. Taylor

Maureen Ding

Peter Welch

Ben Chandler

Steven Dean

Joni Savel

Reifa M. Savel

John Kline

Ed Robb

Steve Womack (NR-3)

John Lewis

Scott Ugen

Joe Wald FL.08

Martha Roby

Di Alf

Kit

Trey Gandy

Bill Johnson

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Carl

Rob

Chris

Vicky Hartzler

Brad Eiler

~~Robert~~

Fewer

Magic K. Hirono

~~Tom Scott~~
Mike R

1. Tom Latham
2. Richard Neal
3. Hank Johnson
4. Michael Capuano
5. Ron Kind
6. Joe Donnelly
7. Dave Loebsack
8. Richard Nugent
9. Reid Ribble
10. Larry Kissell
11. Niki Tsongas
12. Mike Pompeo
13. Jim Renacci
14. Bill Schuster
15. Grace Napolitano
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17. Tim Walz
18. Michael Michaud
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35. Sean Duffy
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38. Barney Frank
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43. Charlie Dent
44. John Oliver
45. Jaime Herrera Beutler
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49. Rosa Deloro

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51. **Cathy McMorris Rodgers**
52. **Sanford Bishop**
53. **Jim Matheson**
54. **Jim Gerlach**
55. **C.A. Dutch Ruppersberger**
56. **Tom Petri**
57. **Nick Rahall**
58. **Pete Sessions**
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63. **Randy Forbes**
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65. **Bill Pascrell**
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79. Marsha Blackburn
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84. Darrell Issa
85. Paul Tonko
86. David McKinley
87. Mike Thompson
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89. Joe Courtney
90. Brett Guthrie
91. Frederica Wilson
92. Health Shuler
93. Tim Murphy
94. Rodney Alexander
95. Martin Heinrich
96. Jim McGovern
97. Leonard Lance
98. Frank Pallone
99. Vern Buchanan

100. **Bill Keating**
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110. **John Campbell**
111. **John Shimkus**
112. **Donald Manzullo**
113. **Stephen Lynch**
114. **Maurice Hinchey**
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134. Martha Roby
135. Tom Price
136. John Kline
137. Joe Walsh
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139. Nita Lowey
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141. Rick Larsen
142. Brad Miller
143. Dan Boren
144. Trey Gowdy
145. Christopher Murphy
146. Peter DeFazio
147. Dennis Cardoza

- 148. **Edolphus Towns**
- 149. **Mazie Hirono**
- 150. **Roscoe Bartlett**
- 151. **David Scott**
- 152. **Vicky Hartzler**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUL 23 2014

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter expressing concern about the prior authorization (PA) process in the March 10 final guidance on Part D Payment for Drugs for Beneficiaries Enrolled in Hospice. Our goal for the policy we set forth in March was to help ensure that the hospice and Part D programs correctly pay for prescription drugs covered under each respective Medicare benefit while preserving timely access to needed prescription medications. While this remains the Centers for Medicare & Medicaid Services' objective, we recognize that the operational challenges associated with prior authorizing all drugs for beneficiaries who have elected hospice to determine whether the drug is coverable under Part D have created difficulties for Part D sponsors and hospice providers, and in some cases, barriers to access for beneficiaries. Therefore, after consulting with beneficiary advocates, hospice providers, Part D sponsors, pharmacies, and other stakeholders, on July 18, 2014, we issued revised guidance to address both the beneficiary access issues and the operational concerns encountered by the industry.

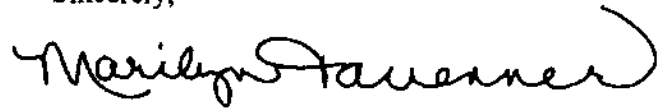
Drugs and biologicals covered under the Medicare Part A per-diem payments to a Medicare hospice program are excluded from coverage under Part D. However, given the aforementioned access and operational issues, in lieu of placing a beneficiary-level prior authorization on all drugs for beneficiaries who have elected hospice, in our revised guidance, we have encouraged sponsors to place beneficiary-level PA requirements on only four categories of prescription drugs: analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs (anxiolytics). Working with the National Hospice and Palliative Care Organization, the Department of Health and Human Services' Office of the Inspector General (OIG) identified these four categories of drugs in its 2012 report as typically used to treat the common symptoms of pain, nausea, constipation, and anxiety that hospice beneficiaries generally experience during the end of life, regardless of terminal diagnosis. Part D sponsors are not expected to impose hospice-beneficiary-level PA on other categories of drugs.

We expect that Medicare hospice providers will continue to provide all of the medications that are reasonable and necessary for the palliation and management of a beneficiary's terminal illness and related conditions. We expect that this will routinely include the drugs in the four categories highlighted by the OIG 2012 report. Therefore, we anticipate these drugs are the least likely to be the subject of disputes concerning payment responsibility. Together with other steps taken to facilitate the PA process, this revised guidance on hospice PA should minimize any barriers to hospice beneficiary access to prescription drugs at the end of life.

Page 2 – The Honorable Tom Price

Thank you for your interest and support as we work to protect beneficiaries' access to prescription medications and the Medicare program. Please do not hesitate to contact me with any further thoughts or concerns. I will also provide this response to the co-signers of this letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

June 30, 2014

The Honorable Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

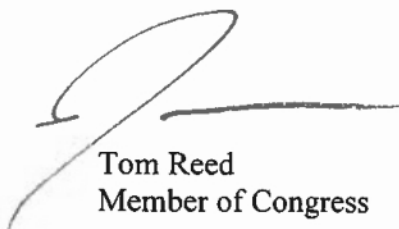
We write today regarding the Medicare Hospice Benefit to share our concerns and comments we have been hearing from district stakeholders. While we continue to support CMS's efforts to ensure program integrity and the continuation of efficient and effective programs, we have heard concerns from beneficiaries regarding the March 10, 2014 directive that sets forth a prior authorization process to avoid double payments for the medications of Part D beneficiaries who have elected hospice. This Guidance has created significant confusion among the impacted stakeholder communities and is leaving hospice beneficiaries without the medications they require. A similar letter was sent to your office during the December 2013 comment period for the Guidance expressing concerns, a copy of which we have attached for your reference.

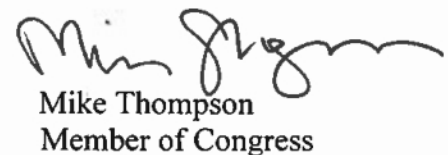
We encourage you to use your existing authority and delay the implementation of the *Part D Payment for Drugs for Beneficiaries Enrolled in Hospice Final Guidance* for 2014 until a uniform and enforceable policy that does not negatively impact beneficiary care is created and the appropriate infrastructure for the provider communities can be thoughtfully and efficiently developed. Further, a temporary delay in implementation would afford CMS the opportunity to work collaboratively with stakeholders and policymakers, to consider policy options and hospice payment reform proposals to determine appropriate reimbursement for drugs for hospice patients that takes into account the patient's individualized hospice care plan and the clinical determinations of their health care professionals.


Many patients and families who depend on hospice face physical and emotional vulnerabilities as they near the end of life. The demographics and patient population being served may have changed since the benefit was implemented, but the need for compassionate, patient-focused end-of-life care remains. We hope that CMS will proceed with greater caution and seriously engage all impacted stakeholder communities as you deal with these issues in the future.


Should you have any questions regarding this request, please do not hesitate to contact Laura Ringdahl in Rep. Tom Reed's office at (202) 225-3161 or by email at Laura.Ringdahl@mail.house.gov or Lakecia Foster in Rep. Mike Thompson's office at (202) 225-3311 or by email at Lakecia.Foster@mail.house.gov.


Sincerely,



Tom Reed
Member of Congress



Mike Thompson
Member of Congress

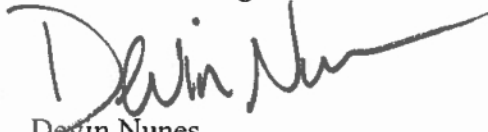

Charles W. Boustany, Jr., M.D.
Member of Congress

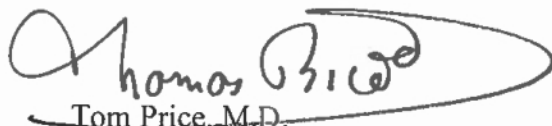

Diane Black
Member of Congress

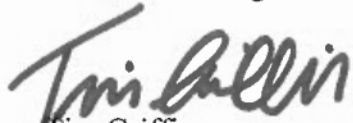

Erik Paulsen
Member of Congress



Patrick J. Tiberi
Member of Congress

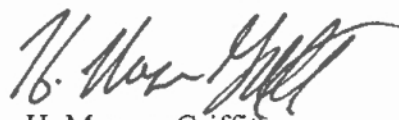

Vern Buchanan
Member of Congress


Devin Nunes
Member of Congress

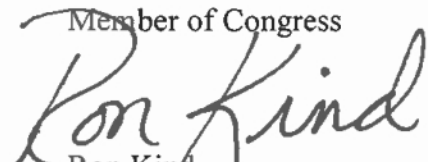

Tom Price, M.D.
Member of Congress


Tim Griffin
Member of Congress


Marsha Blackburn
Member of Congress

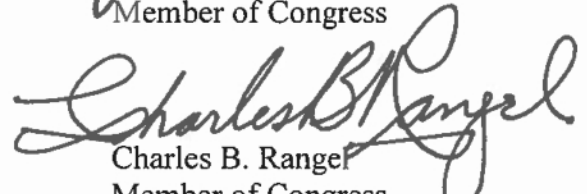

H. Morgan Griffith
Member of Congress

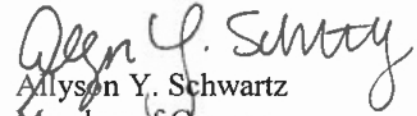

Earl Blumenauer
Member of Congress



Ron Kind
Member of Congress

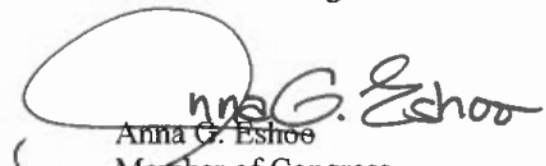

Lloyd Doggett
Member of Congress

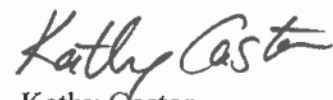

John B. Larson
Member of Congress


Charles B. Rangel
Member of Congress


Allyson Y. Schwartz
Member of Congress


Paul Tonko
Member of Congress


Anna G. Eshoo
Member of Congress


Kathy Castor
Member of Congress


Bruce L. Braley
Member of Congress

Cory Gardner
Member of Congress

Diana DeGette
Member of Congress

Leonard Lance
Member of Congress

Collin C. Peterson
Member of Congress

David McKinley
Member of Congress

Colleen W. Hanabusa
Member of Congress

Lee Terry
Member of Congress

Raul M. Grijalva
Member of Congress

Chris Gibson
Member of Congress

Nick J. Rahall, II
Member of Congress

Lynn Westmoreland
Member of Congress

William L. Owens
Member of Congress

Vance McAllister
Member of Congress

Henry C. "Hank" Johnson
Member of Congress

Paul C. Broun, M.D.
Member of Congress

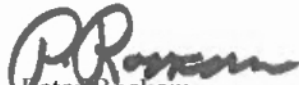
Chellie Pingree
Member of Congress

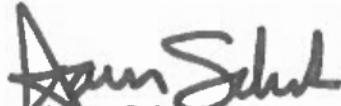
Shelley Moore Capito
Member of Congress


Louise M. Slaughter
Member of Congress


Steve Daines
Member of Congress

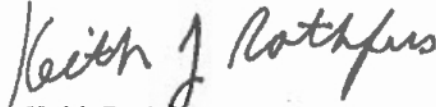
Michael H. Michaud
Member of Congress

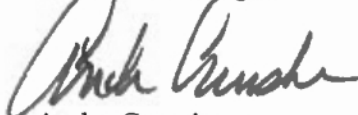

Peter Roskam
Member of Congress

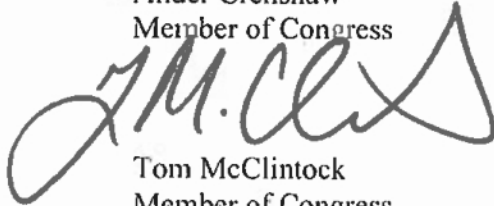

Aaron Schock
Member of Congress



Austin Scott
Member of Congress


Dan Benishek, M.D.
Member of Congress



Keith Rothfus
Member of Congress


Ander Crenshaw
Member of Congress



Tom McClintock
Member of Congress

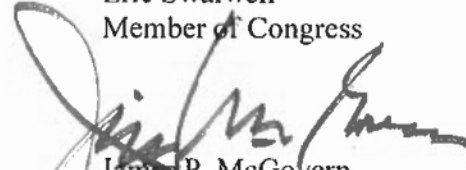

Jackie Walorski
Member of Congress

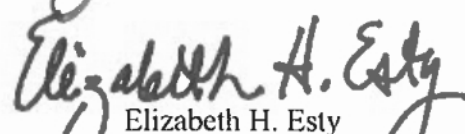

Tom Cotton
Member of Congress


Scott DesJarlais, M.D.
Member of Congress



Alan Lowenthal
Member of Congress

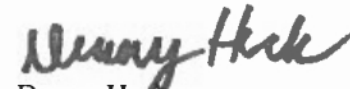

Eric Swalwell
Member of Congress

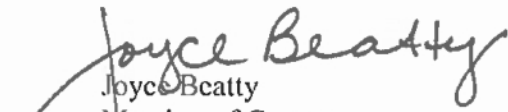

James P. McGovern
Member of Congress



Elizabeth H. Esty
Member of Congress

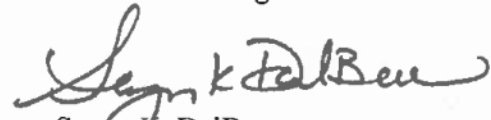

Tulsi Gabbard
Member of Congress


Pete P. Gallego
Member of Congress


Denny Heck
Member of Congress


Joyce Beatty
Member of Congress


Ann Kirkpatrick
Member of Congress


Suzan K. DelBene
Member of Congress

Phil Roe

Phil Roe, M.D.
Member of Congress

Bradley S. Schneider

Bradley S. Schneider
Member of Congress

John Yarmuth

John Yarmuth
Member of Congress

William R. Keating

William R. Keating
Member of Congress

Peter King

Peter King
Member of Congress

Mark Pocan

Mark Pocan
Member of Congress

Tom Rice

Tom Rice
Member of Congress

David Scott

David Scott
Member of Congress

Candice S. Miller

Candice S. Miller
Member of Congress

Jackie Speier

Jackie Speier
Member of Congress

Brett Guthrie

Brett Guthrie
Member of Congress

Ann McLane Kuster

Ann McLane Kuster
Member of Congress

Kerry L. Bentivolio

Kerry L. Bentivolio
Member of Congress

David N. Cicilline

David N. Cicilline
Member of Congress

Duncan Hunter

Duncan Hunter
Member of Congress

James R. Langevin

James R. Langevin
Member of Congress

Scott Tipton

Scott Tipton
Member of Congress

Tammy Duckworth

Tammy Duckworth
Member of Congress

Jim Bridenstine

Jim Bridenstine
Member of Congress

Robert A. Brady

Robert A. Brady
Member of Congress

Patrick Meehan
Member of Congress

Joe Heck, D.O.
Member of Congress

Michael McCaul
Member of Congress

Glenn "GT" Thompson
Member of Congress

Jeff Duncan
Member of Congress

Cynthia Lummis
Member of Congress

Mike Pompeo
Member of Congress

Rick Crawford
Member of Congress

Bill Johnson
Member of Congress

Jim Cooper
Member of Congress

Betty McCollum
Member of Congress

Michael M. Honda
Member of Congress

Chris Van Hollen
Member of Congress

John Delaney
Member of Congress

Juan Vargas
Member of Congress


Gary C. Peters
Member of Congress

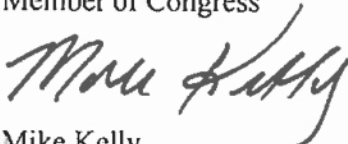
Niki Tsongas
Member of Congress

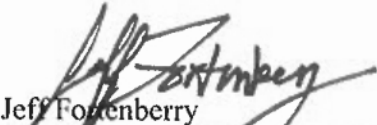
Andy Harris, M.D.
Member of Congress

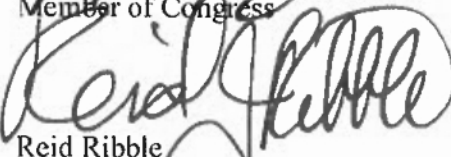
Carol Shea-Porter
Member of Congress

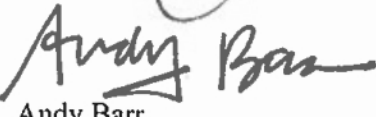
Sean Patrick Maloney
Member of Congress

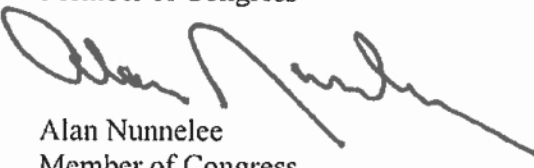

David Joyce
Member of Congress

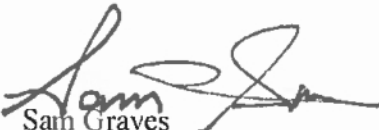

Mike Kelly
Member of Congress


Jeff Fortenberry
Member of Congress

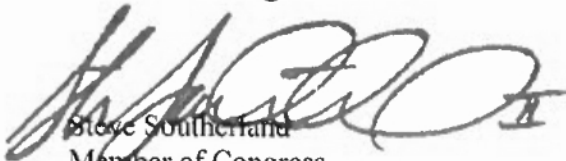

Reid Ribble
Member of Congress

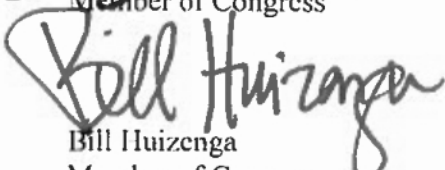

Andy Barr
Member of Congress



Alan Nunnelee
Member of Congress



Sam Graves
Member of Congress

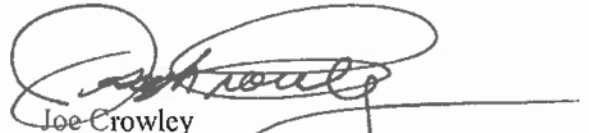

Jon Runyan
Member of Congress

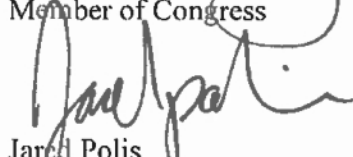

Steve Southerland
Member of Congress



Bill Huizenga
Member of Congress

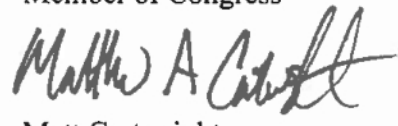

Dave Loebsack
Member of Congress

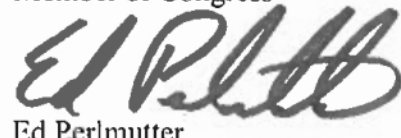

Susan Davis
Member of Congress

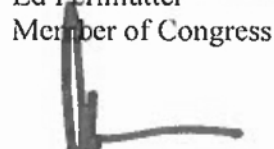

Joe Crowley
Member of Congress



Jared Polis
Member of Congress

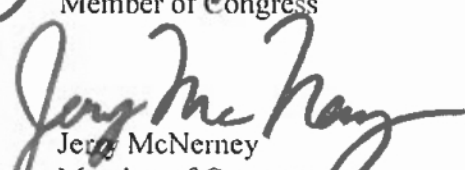

Tim Ryan
Member of Congress


Matt Cartwright
Member of Congress

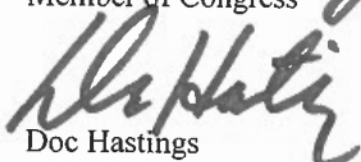

Ed Perlmutter
Member of Congress



Ami Bera, M.D.
Member of Congress

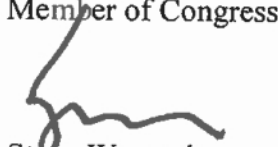

Zoe Lofgren
Member of Congress

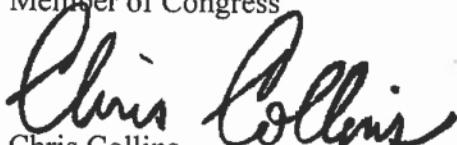

Jerry McNerney
Member of Congress



Sean Duffy
Member of Congress



Doc Hastings
Member of Congress



Jaime Herrera Beutler
Member of Congress

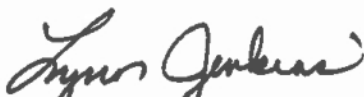

Steve Womack
Member of Congress

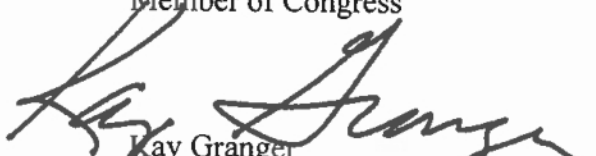

Chris Collins
Member of Congress

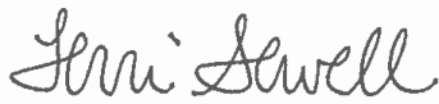

Markwayne Mullin
Member of Congress

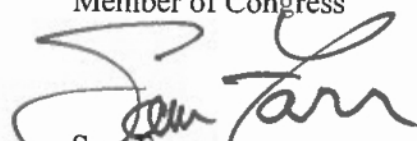

Kevin Cramer
Member of Congress

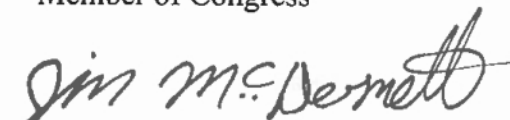

Bill Flores
Member of Congress


Lynn Jenkins
Member of Congress

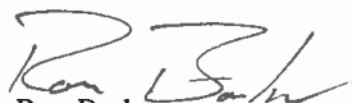

Kay Granger
Member of Congress


Terri A. Sewell
Member of Congress



Sam Farr
Member of Congress

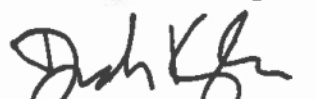

Jim McDermott
Member of Congress

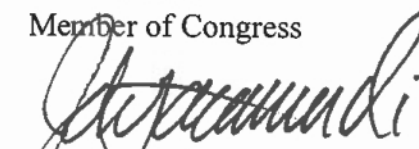

Tim Walz
Member of Congress



Ron Barber
Member of Congress


Steve Israel
Member of Congress


Richard M. Nolan
Member of Congress

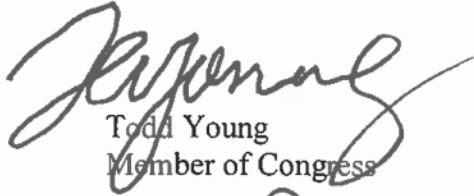

Derek Kilmer
Member of Congress


John Garamendi
Member of Congress

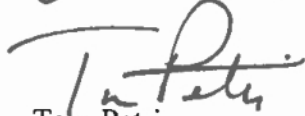

Doris O. Matsui
Member of Congress



Steve Stivers
Member of Congress



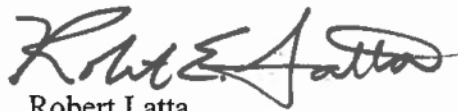
Todd Young
Member of Congress



Tom Petri
Member of Congress



Tom Cole
Member of Congress



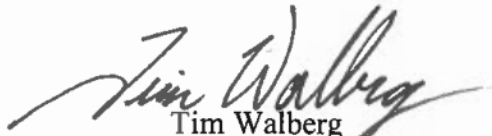
Robert Latta
Member of Congress



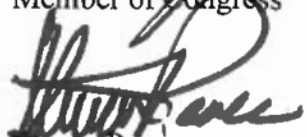
Mike Coffman
Member of Congress



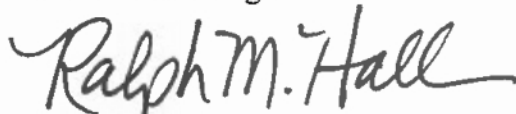
Blaine Luetkemeyer
Member of Congress



Tim Walberg
Member of Congress



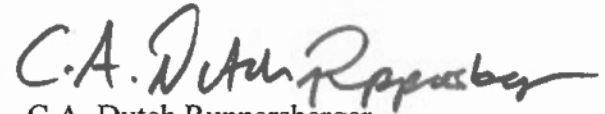
Evian Pearce
Member of Congress



Ralph Hall
Member of Congress



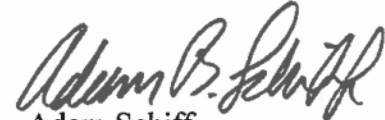
Mike McIntyre
Member of Congress



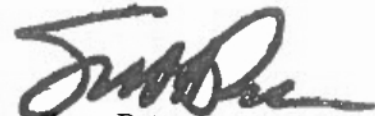
C.A. Dutch Ruppberger
Member of Congress



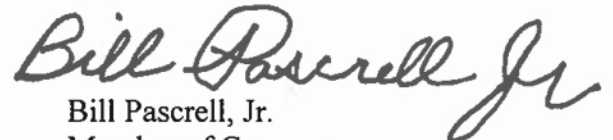
Rosa DeLauro
Member of Congress



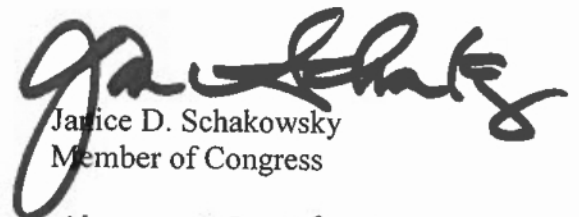
Adam Schiff
Member of Congress



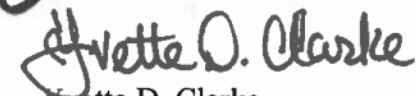
Scott Peters
Member of Congress



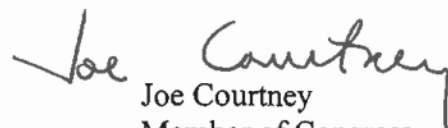
Bill Pascrell, Jr.
Member of Congress




Janice D. Schakowsky
Member of Congress



Yvette D. Clarke
Member of Congress



Joe Courtney
Member of Congress



Carolyn McCarthy
Member of Congress



Christopher H. Smith
Member of Congress



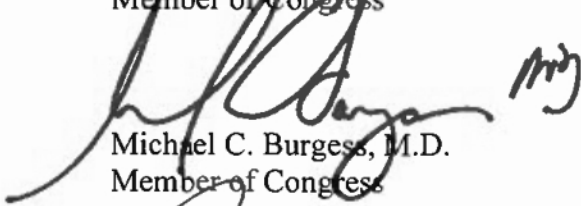
Peter Welch
Member of Congress



Steve Chabot
Member of Congress



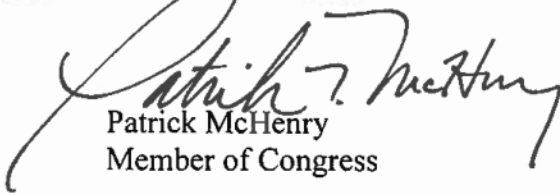
Barbara Lee
Member of Congress



Michael C. Burgess, M.D.
Member of Congress



Adam Smith
Member of Congress



Patrick McHenry
Member of Congress



Gwen Moore
Member of Congress



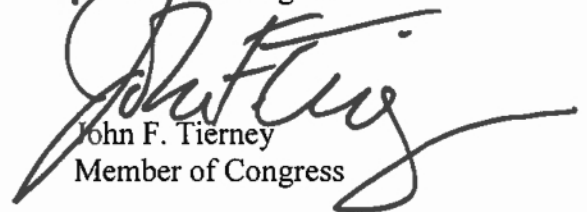
Walter Jones
Member of Congress



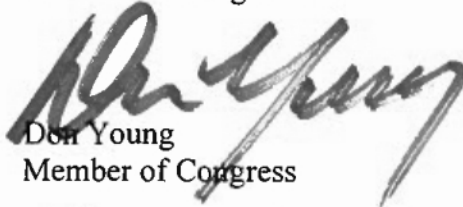
Keith Ellison
Member of Congress



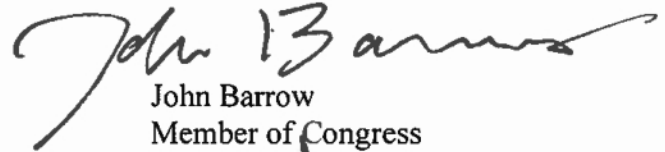
Mac Thornberry
Member of Congress



John F. Tierney
Member of Congress



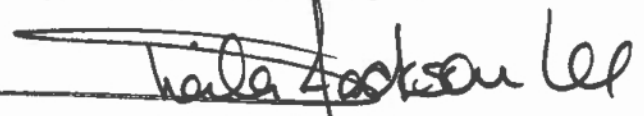
Don Young
Member of Congress



John Barrow
Member of Congress



Gus Bilirakis
Member of Congress



Sheila Jackson Lee
Member of Congress



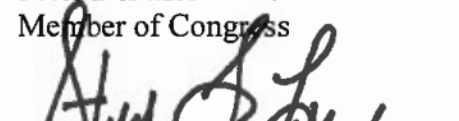
Ken Calvert
Member of Congress



Peter DeFazio
Member of Congress



Louie Gohmert
Member of Congress



Stephen Lynch
Member of Congress



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

JUL 20 2009

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Mr. Price:

Thank you for your letter regarding payments to ambulatory surgery centers urging the adoption of two key policies that would maintain the alignment between payments in the ambulatory surgery center and the hospital outpatient department.

The proposed rule, CMS-1414-P, "Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for CY 2010," was displayed at the Office of the Federal Register on July 1, with a comment period that ends on August 31.

One of the purposes of the proposed rule is to solicit comments from interested parties. All comments received during the comment period will be considered before the final rule is published. A summary of the comments and our responses will also be included with the final regulation.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink that reads "Charlene Frizzera".

Charlene Frizzera
Acting Administrator

07022009 4038

Congress of the United States
Washington, DC 20515

June 26, 2009

RECEIVED
JUL - 2 2009
OSORA, DIVISION
OF CORRESPONDENCE MANAGEMENT

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Frizzera:

We are writing to request your assistance to address a significant problem that threatens patient access to cost-effective surgical care – adequate payments to ambulatory surgery centers. As you know, ASCs have been subjected to a six year freeze and now confront a possible negative update in 2010 because their payment updates are unrelated to their input costs.

We are writing to urge the Centers for Medicare and Medicaid Services (CMS) to adopt two key policies that would maintain the alignment between payments in the ambulatory surgery center (ASC) and hospital outpatient department (HOPD) – 1) apply the hospital market basket inflation factor to ASC payments in 2010, instead of the Consumer Price Index for Urban consumers (CPI-U) factor used in the past and 2) utilize the same relative weights across settings. We are concerned that if the ASC-HOPD payment gap continues to grow, in the very near future certain procedures or classes of surgical services will no longer be viable in the ASC setting.

ASCs provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare beneficiaries choose ASCs for their outpatient surgery, both the beneficiary and the Medicare program save money – routinely over \$450 million per year in savings to Medicare for comparable services. ASCs are a critical point of access for important screening benefits and other nondiscretionary services such as diagnostic colonoscopies and cataract removal surgery. Given that ASCs are the provider of choice for these and other benefits in many markets, establishing an appropriate ASC payment update factor is important to ensuring continued access to services which improve and extend beneficiaries' quality of life.

Now that ASC payments are linked to the hospital outpatient prospective payment system (OPPS), we urge you to adopt policies that maintain the alignment between ASC and HOPD payments. In particular:

- CMS should apply outpatient prospective payment system (OPPS) relative weights directly to the ASC payment rates instead of applying a secondary "rescaling" of the ASC rates.
- CMS should apply the same market basket updates to ASCs as HOPDs.

The primary cause of the growing divergence between ASC and hospital outpatient department payments is the failure to use the same relative weights for surgical procedures in both the OPPS and ASC systems. We do not believe this policy is in the best interest of the Medicare program or its beneficiaries. At a time when Medicare is struggling to contain overall costs, it does not make sense to penalize providers who are able to perform services more efficiently. Nothing in the statute requires such a budget neutrality adjustment. In addition, severing the link between the OPPS and the ASC payment system undermines CMS's broader efforts to improve transparency for Medicare beneficiaries.

Finally, we believe the hospital market basket unquestionably is a more appropriate basis for annual ASC updates than the CPI-U. ASCs are the only Medicare providers for which payment updates are determined using the CPI-U, an index designed to serve as an economy-wide measure of consumer inflation and driven by changes in energy and housing prices. The CPI-U inputs do not reflect the items and services that ASCs must purchase in order to provide care for their patients.

The hospital market basket, however, is based on factors directly related to the cost of providing outpatient services – inflationary pressures shared by both hospitals and ASCs. Yet tying ASCs to a separate update mechanism would cause payments to hospitals and ASCs to diverge over time with no relation to their actual costs. This year, for example, the market basket update will yield an increase of slightly below 3% for HOPDs, whereas the CPI-U was negative for the first quarter of this year and may remain so for the year.

It is our understanding that CMS has the authority to implement the hospital market basket as the index for updating ASC payments. Section 1833(i)(2)(C)(i) of the Social Security Act requires that the Secretary update the payment amounts established under the revised system by the CPI-U as a **default**, but only if the Secretary has not otherwise updated the payments for that year. The statute, therefore, does not mandate the adoption of any particular update mechanism. CMS can, and should, update its policies to establish the hospital market basket as an alternative ASC update mechanism. In fact, CMS noted the breadth of authority around updating ASC payments when implementing the new system.

Use of the hospital market basket would offer the additional benefit of more fully aligning the revised ASC payment system with the hospital outpatient prospective payment system (OPPS). The continued application of different inflation update factors for these settings drives a difference in the conversion factor between the OPPS and the ASC that is unrelated to the actual cost of performing procedures and only adds to the growing gap between ASC and hospital outpatient department payments for the same services. In other major payment systems, such as skilled nursing facility and home health services, CMS appropriately ties payments to market baskets constructed to reflect the change in

prices for the items used in each setting. Similar consideration should be applied to the ASC setting.

Now is an opportune time for the agency to recognize the similar resource requirements and inflationary pressures facing ASCs and HOPDs, and adopt the hospital market basket for ASC updates. There are no real differences in the growth of the cost of goods and services provided by ASCs and HOPDs, and therefore inequitable updates should not be perpetuated by policies the agency has the administrative authority to correct.

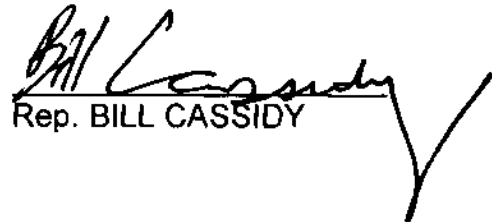
Thank you for your review and consideration of this important issue. We would appreciate an update on your policy development in this area as soon as possible.

Sincerely,


Rep. KENDRICK B. MEEK


Rep. WALLY HERGER



Rep. RON PAUL


Rep. BILL CASSIDY

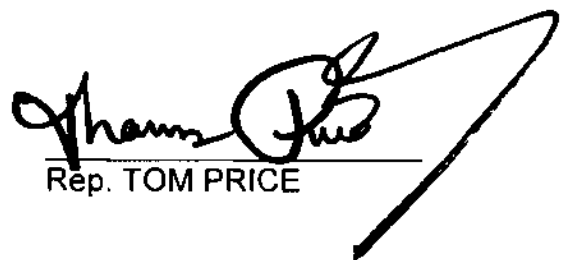

Rep. JOHN P. MURTHA


Rep. W. TODD AKIN


Rep. DAVID P. ROE


Rep. Wm. LACY CLAY


Rep. MICHAEL C. BURGESS


Rep. TOM PRICE

Cont.


Rep. BRUCE L. BRALEY


Rep. MARSHA BLACKBURN


Rep. DONALD M. PAYNE


Rep. DOUG LAMBORN



SEP 24 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
United States House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter sharing your concerns regarding the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Currently, there are two pathways for pathologists who are not meaningful EHR users to receive an exemption from the Medicare payment adjustment.

The first pathway is for hospital-based eligible professionals. The statute prohibits application of the payment adjustment to hospital-based eligible professionals (42 U.S.C. section 1395w-4(a)(7)(D)). In regulation, this term is defined as an eligible professional who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the payment year, or in the case of a payment adjustment year, in either of the two years before the year preceding such payment adjustment year (42 CFR section 495.4). Pathologists who are determined to be "hospital-based" by the Centers for Medicare & Medicaid Services (CMS) will be exempt from the payment adjustment. The payment adjustment exemption for hospital-based eligible professionals is not subject to any statutory or regulatory time limit. We believe this permanent statutory exemption provides relief from the Medicare payment adjustment for hospital-based pathologists.

The second pathway is a statutory significant hardship exception, under which the Secretary may exempt an eligible professional, on a case-by-case basis, from the application of the Medicare payment adjustment if the Secretary determines, subject to annual renewal, that compliance with the requirement to be a meaningful EHR user would result in a significant hardship (42 U.S.C. section 1395w-4(a)(7)(B)). We established various categories of hardship exceptions in rulemaking (Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2, 77 Fed. Reg. 53,968, 54,093-54,113 [Sept. 4, 2012]). One such category under 42 CFR section 495.102(d)(4) is for eligible professionals whose primary specialty is listed in the Medicare Provider Enrollment, Chain, and Ownership System as anesthesiology, radiology, or pathology six months prior to the first day of the year in which payment adjustments would apply. The statute prohibits an eligible professional from being granted a significant hardship exception for more than five years.

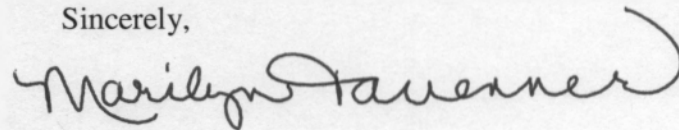
In rulemaking, CMS stated that it will work to develop strategies to assist physicians such as pathologists, who lack face-to-face interactions or the need to follow up with patients in demonstrating meaningful use (77 Fed. Reg. 54099). CMS also stated that pathologists should not expect to be granted an exception for the full 5-year period allowed under the statute, or that the exception will continue indefinitely. Rather, we have encouraged pathologists to continue building out their ability to participate in health information exchange and adopt EHRs. As

Page 2 – The Honorable Tom Price, M.D.

noted in your letter, we are currently developing the Stage 3 proposed rule and expect to release it within the next few months. CMS encourages stakeholders in the pathology community to comment on any proposals set forth in the Stage 3 proposed rule addressing the significant hardship exception.

Thank you for your interest in the EHR Incentive Programs. Please do not hesitate to contact me with any further thoughts or concerns. I will also provide a copy of this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

July 10, 2014

Marilyn Tavenner
Administrator Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-18559

Dear Administrator Tavenner:

We write to ask that CMS, in its upcoming Stage 3 Electronic Health Record (EHR) Incentive Program proposed rule, grant a significant hardship exception to all eligible pathologists for the full five year maximum allowed under the American Recovery and Reinvestment Act (ARRA). As you know, ARRA established the EHR Incentive Programs for Medicare and Medicaid to provide payments to eligible hospitals and eligible professionals for implementing EHRs in ways that can positively impact patient care.

In its September 2012 Final Stage 2 Electronic Health Record Incentive Program rule, CMS acknowledged that pathologists face significant barriers in meeting the current meaningful use requirements, as evidenced by CMS' granting of the significant hardship exception to pathologists for 2015 – the first year of payment adjustments. Laboratory testing and pathology diagnostic information are without question a key influence on health care decision making.

The EHR Meaningful Use Program is designed to incentivize the adoption of EHRs. Pathologists have limited direct contact with patients and do not operate in EHRs. Instead, pathologists use sophisticated computerized laboratory information systems (LISs) to support the work of analyzing patient specimens and generating test results. These LISs exchange laboratory and pathology data with EHRs.

As a result, pending SGR legislation (H.R. 4015, the *SGR Repeal and Medicare Provider Payment Modernization Act of 2014*) recognizes that it is exceedingly difficult for non-patient-facing professionals, such as pathologists, to meet the current requirements of certain quality programs, including the EHR Meaningful Use Program. Therefore, the SGR legislation includes language giving the Secretary of Health and Human Services the flexibility to create measures and activities under the Merit-Based Incentive Payment System that reflect the way pathologists, and other physicians that do not have direct interaction with patients, practice medicine.

In conclusion, we request that CMS grant all eligible pathologists the significant hardship exception from meaningful use incentives and penalties for the full five years allowed under current law. Thank you in advance for your consideration of our request. We remain committed to working with you to enhance the requirements of the program and look forward to your reply.

Sincerely,



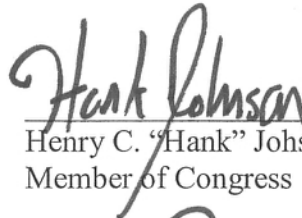
Ron Kind
Member of Congress



Tom Price, M.D.
Member of Congress



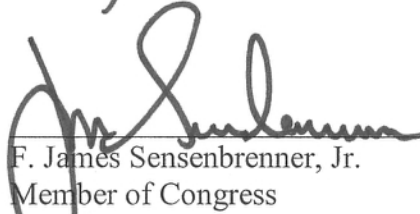
Jim Matheson
Member of Congress



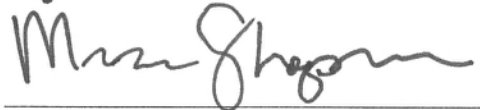
Henry C. "Hank" Johnson
Member of Congress



Jim Moran
Member of Congress




F. James Sensenbrenner, Jr.
Member of Congress



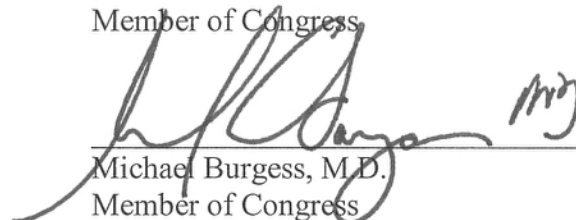
Mike Thompson
Member of Congress




Phil Roe, M.D.
Member of Congress



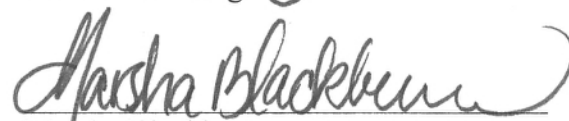
Chris Stewart
Member of Congress



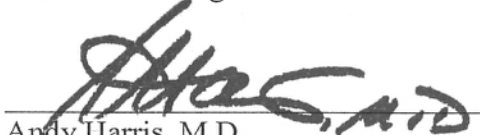
Michael Burgess, M.D.
Member of Congress



Tim Griffin
Member of Congress



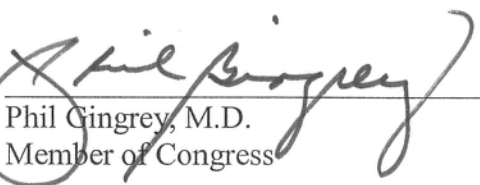
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Member of Congress



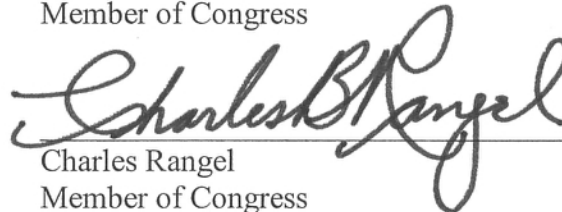
Andy Harris, M.D.
Member of Congress



Blake Farenthold
Member of Congress



Phil Gingrey, M.D.
Member of Congress

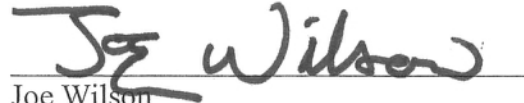



Charles Rangel
Member of Congress


Bill Johnson
Member of Congress



Bill Posey
Member of Congress

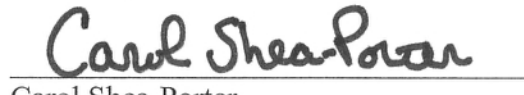

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Member of Congress


Joe Wilson
Member of Congress

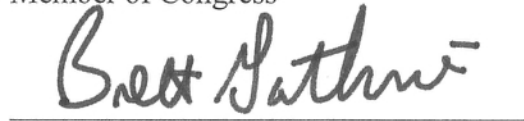

Peter Roskam
Member of Congress

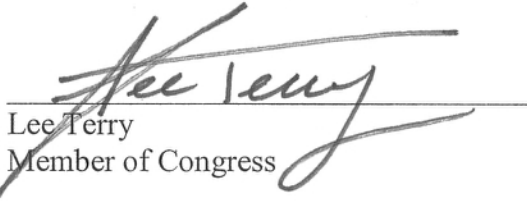

Charles Boustany, M.D.
Member of Congress



Lynn Jenkins
Member of Congress


Carol Shea-Porter
Member of Congress


Denny Heck
Member of Congress

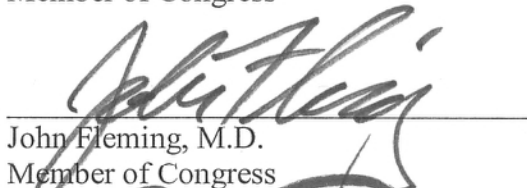

Brett Guthrie
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Lee Terry
Member of Congress


Stephen Fincher
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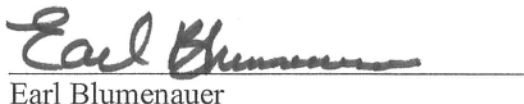

Vern Buchanan
Member of Congress


Eliot Engel
Member of Congress


John Fleming, M.D.
Member of Congress


G. K. Butterfield
Member of Congress


Ted Deutch
Member of Congress


Earl Blumenauer
Member of Congress

Brian Higgins

Brian Higgins
Member of Congress

Howard Coble

Howard Coble
Member of Congress

Keith J. Rothfus

Keith Rothfus
Member of Congress

Richard Hanna

Richard Hanna
Member of Congress

William L. Enyart

William Enyart
Member of Congress

Bobby L. Rush

Bobby L. Rush
Member of Congress

Diane Black

Diane Black
Member of Congress

Larry Bucshon

Larry Bucshon
Member of Congress

Richard Neal

Richard Neal
Member of Congress

Dan Benishek

Dan Benishek, M.D.
Member of Congress

Dave Loebsack

Dave Loebsack
Member of Congress

Leonard Lance

Leonard Lance
Member of Congress

Alan Nunnelee

Alan Nunnelee
Member of Congress

David Valadao

David Valadao
Member of Congress

Walter B. Jones

Walter Jones
Member of Congress

Chris Collins

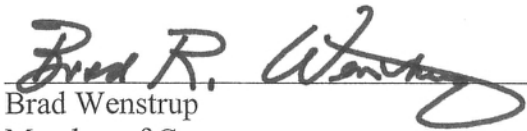
Chris Collins
Member of Congress

Gus Bilirakis

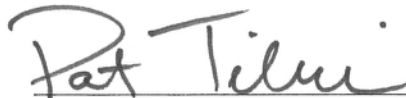
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Member of Congress

Michelle Lujan Grisham

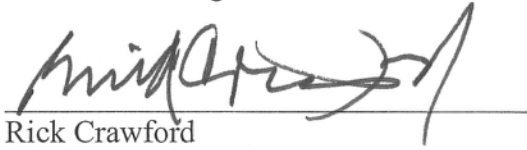
Michelle Lujan Grisham
Member of Congress



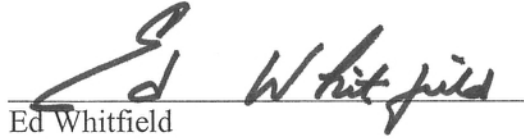
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Member of Congress



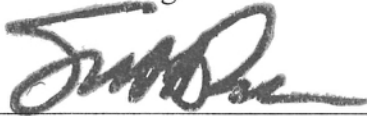
Pat Tiberi
Member of Congress



Rick Crawford
Member of Congress



Ed Whitfield
Member of Congress



Scott Peters
Member of Congress



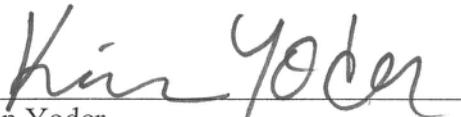
Billy Long
Member of Congress



Tom Graves
Member of Congress



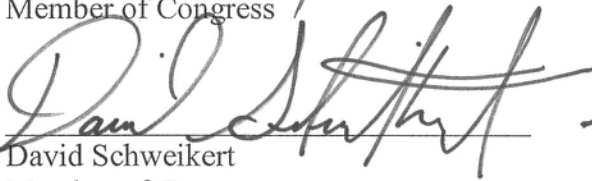
Gerry Connolly
Member of Congress



Kevin Yoder
Member of Congress



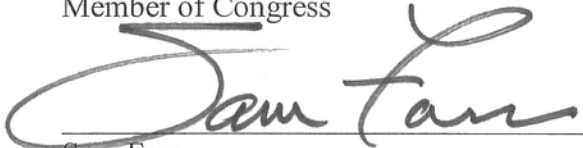
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Member of Congress



David Schweikert
Member of Congress



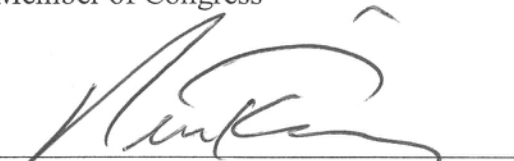
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Member of Congress



Sam Farr
Member of Congress



Jackie Speier
Member of Congress



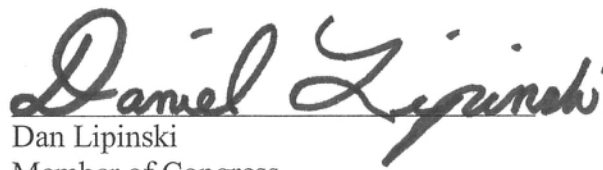
Peter King
Member of Congress



Ted Poe
Member of Congress



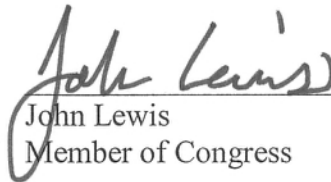
Cheri Bustos
Member of Congress



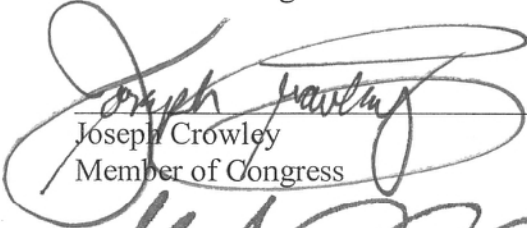
Dan Lipinski
Member of Congress



John Barrow
Member of Congress



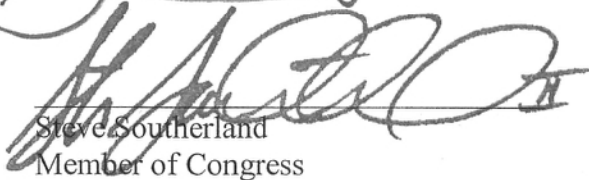
John Lewis
Member of Congress



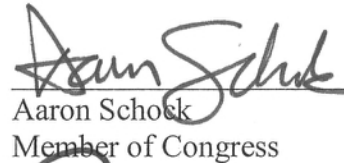
Joseph Crowley
Member of Congress



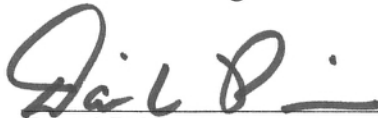
Jaime Herrera Beutler
Member of Congress



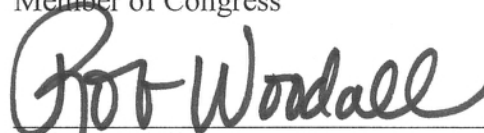
Steve Southerland
Member of Congress



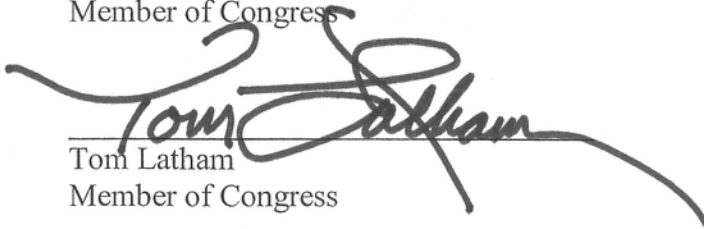
Aaron Schock
Member of Congress



David Price
Member of Congress



Rob Woodall
Member of Congress



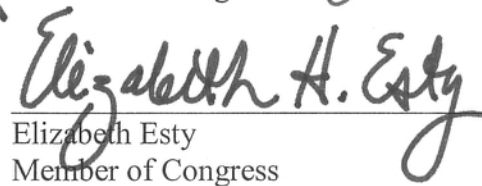
Tom Latham
Member of Congress



Todd Young
Member of Congress



Sean Maloney
Member of Congress



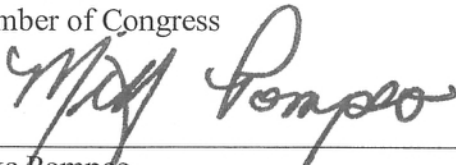
Elizabeth Esty
Member of Congress



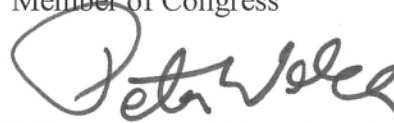
Steve Israel
Member of Congress



Ben Ray Lujan
Member of Congress



Mike Pompeo
Member of Congress



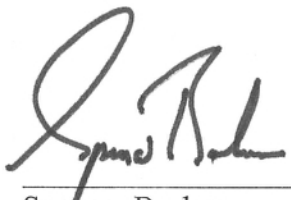
Peter Welch
Member of Congress



Erik Paulsen
Member of Congress



Lois Capps
Member of Congress



Spencer Bachus
Member of Congress



OCT 15 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding your concerns about the lack of certified EHR technology (CEHRT) for ambulatory surgical centers (ASC) and issues regarding participation in the Medicare Electronic Health Records (EHR) Incentive Program.

You state that eligible professionals who see the majority of their patients in an ASC may not be able to meet meaningful use requirements due to the lack of (CEHRT) for the ASC setting. It is accurate that ASCs are not eligible to participate in the EHR Incentive Program, and that there is no specific CEHRT definition just for an ASC setting. However, in general, eligible professionals (EPs) that perform services in an ASC are eligible to participate in the Medicare EHR Incentive Program. EPs practicing in multiple locations, including an ASC, who have at least 50 percent of their patient encounters during an EHR reporting period at a location or locations equipped with CEHRT can participate in the program. Furthermore, CEHRT does not require that the technology be used in any specific location or health care setting in order to capture patient data. In other words, although some vendors choose to specialize their products for certain target markets, there is no requirement to limit CEHRT specifically to hospitals, EPs, or CAHs as defined by the Centers for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology. Many universal products exist, and many products are used in a wide range of settings in both inpatient and ambulatory care. Any of these general certified EHR technologies could potentially be used in an ASC to capture patient data. Like other EPs, those who furnish services in an ASC setting may apply for a significant hardship exception to the Medicare payment adjustments, although we note there are EPs who practice in an ASC setting that have successfully demonstrated meaningful use.

We will continue to consider the input of stakeholders as we engage in rulemaking for Stage 3 of the EHR Incentive Programs. We encourage stakeholders to further articulate on any specific concerns that stakeholders may have with regard to the use of CEHRT in the ASC setting. Thank you for your concerns and interest in the Medicare EHR Incentive Program. I will also send this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner

Congress of the United States

Washington, DC 20515

July 17, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Tavenner:

We are writing to express concern about an anomaly in the Electronic Health Records (EHR) program, which may cause certain eligible professionals in the Medicare system to be penalized based on the setting in which they see a majority of their patients. Specifically, eligible professionals who see the majority of their patients in ambulatory surgery centers (ASCs) may not be able to meet meaningful use requirements mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act due to the fact that there are no EHRs certified for the ASC setting. We urge you to exempt patient encounters in the ASC setting until an EHR is certified for the ASC setting.

The meaningful use program states that in order to avoid payment penalties beginning as early as 2015, all eligible professionals must conduct 50 percent or more of their Medicare patient encounters in a setting with a certified EHR technology (CEHRT). Unfortunately, ASCs were not included in the HITECH Act. Therefore, a process has not been set up to certify an EHR for the ASC setting. As a result, eligible physicians cannot count patient encounters in the ASC in the numerator as "meaningful use" visits, but must count those encounters in the denominator which represents all patient encounters.

At this time, the only authoritative information available from the Centers for Medicare and Medicaid Services (CMS) indicating how patient encounters in the ASC should be treated is available as a frequently asked question (FAQ) on the CMS website.¹ FAQ 3065 confirms that "an ASC (Place of Service 24) should be included in the denominator of the calculation." If this guidance is applied, many physicians who practice primarily in the ASC, such as gastroenterologists, pain physicians and some ophthalmologists, cannot meet current requirements and will face increasing risk as the threshold rises for this "meaningful use" objective in future years.

While CMS does offer exemptions for certain hardship situations, the guidance is unclear for ASC-based physicians. Furthermore, the available hardship exemptions may not be granted to physician practice owners even though owners have no control over the availability of a CEHRT for the ASC setting.

The EHR Meaningful Use program should help facilitate the implementation of EHR technology to improve care across all settings for America's seniors. Physicians should not have to choose between providing quality, cost effective care in the ASC or sending Medicare patients to a higher cost setting in order to avoid financial penalty.

¹ <https://questions.cms.gov/faq.php?id=5005&faqId=3065>

By seeing patients in an ASC, these doctors are providing high quality care that saves Medicare and our nation's seniors billions of dollars a year. A recent report from the Department of Health and Human Services Office of the Inspector General found that Medicare and beneficiaries could save an additional \$12 billion and \$3 billion, respectively, through 2017 if the lower rates for this efficient setting continue to apply.²

Although no incentives are available, it is our understanding that stakeholders in the ASC community and IT vendors are in the initial stage of developing criteria for a voluntary certification of appropriate electronic health record technology for this unique setting of care.

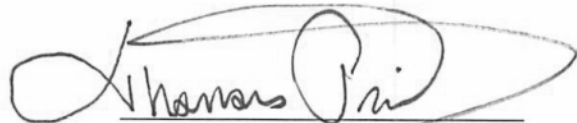
For this reason, we strongly urge that CMS work with the ASC stakeholder groups to expeditiously adopt a voluntary certification program. Furthermore, until such time as a CEHRT is approved for the ASC setting, it is imperative that an exemption be made for ASC patient encounters from an eligible provider's meaningful use calculations.

Thank you for your careful consideration of this important matter. Should you have any questions, do not hesitate to contact Ellen Cain in Congressman Black's office at 202-225-4231 or Ellen.Cain@mail.house.gov.

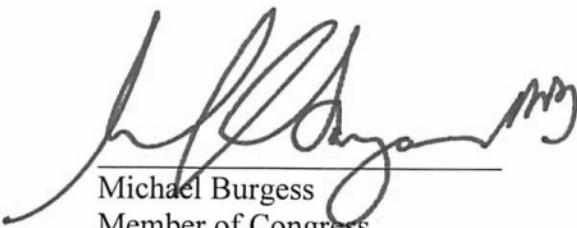
Sincerely,



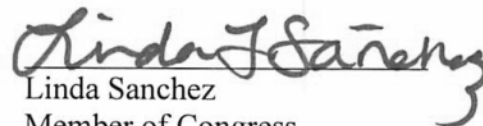
Diane Black
Member of Congress



Tom Price, MD
Member of Congress



Michael Burgess
Member of Congress



Linda Sanchez
Member of Congress

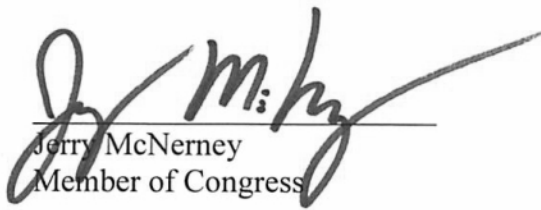



Marsha Blackburn
Member of Congress

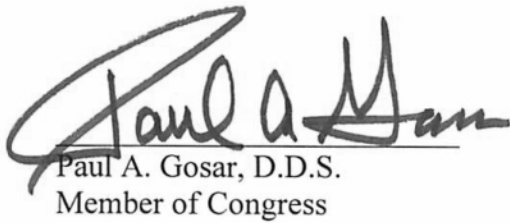


Andy Harris
Member of Congress

² <https://oig.hhs.gov/oas/reports/region5/51200020.asp>

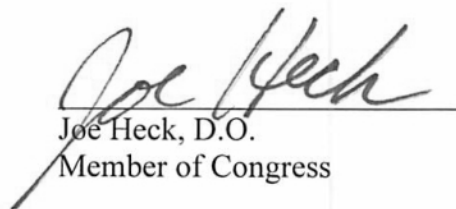

Jerry McNerney
Member of Congress

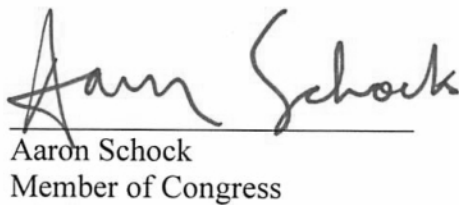

Vern Buchanan
Member of Congress


Paul A. Gosar, D.D.S.
Member of Congress

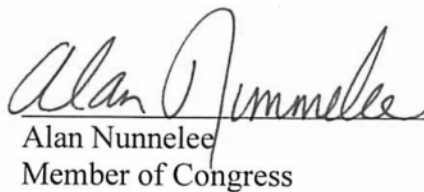

David Scott
Member of Congress


Tim Griffin
Member of Congress

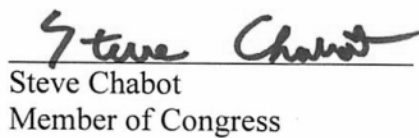

Joe Heck, D.O.
Member of Congress

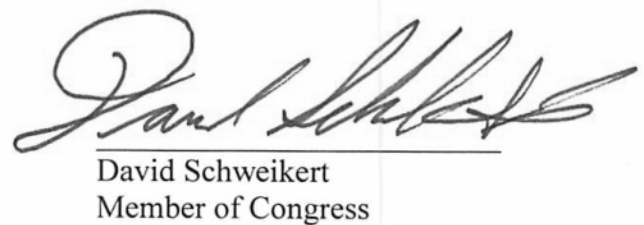

Aaron Schock
Member of Congress


Dan Benishek
Member of Congress


Alan Nunnelee
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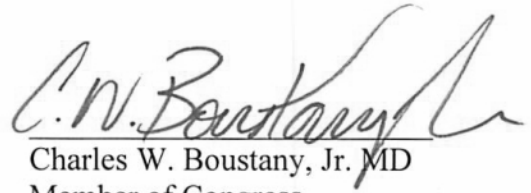

H. Morgan Griffith
Member of Congress


Steve Chabot
Member of Congress


David Schweikert
Member of Congress



Steve Stivers
Member of Congress



Charles W. Boustany, Jr. MD
Member of Congress



Scott Peters
Member of Congress

cc:

Dr. Karen DeSalvo, Office of the National Coordinator for Health Information Technology



Administrator
Washington, DC 20201

SEP 12 2014

The Honorable Tom Rice
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rice:

Thank you for your letter regarding the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. We appreciate receiving feedback on the program, and we are always seeking ways to improve the EHR Incentive Program.

As noted in your letter, the EHR Incentive Program helps both beneficiaries and providers by advancing the use of Certified Electronic Health Record Technology (CEHRT) to transform health care delivery and improve patient outcomes. We remain cognizant of stakeholder concerns like those cited by your constituents, and we strive to balance those concerns with moving the program forward efficiently.

In an effort to grant more flexibility to providers who have experienced issues that affect their ability to fully implement 2014 Edition CEHRT and attest to meaningful use, we recently issued a final rule that provides additional relief for 2014 (*Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition*, 79 Fed. Reg. 52,910 [September 4, 2014]). This rule allows eligible professionals, eligible hospitals, and critical access hospitals to continue to use 2011 Edition CEHRT or a combination of 2011 Edition and 2014 Edition CEHRT for the EHR reporting periods in CY 2014 and FY 2014, respectively, if they are not able to fully implement 2014 Edition CEHRT for a full EHR reporting period in 2014. We believe these options balance the need to move the EHR Incentive Program forward, especially for those providers and vendors who undertook great effort and expense to fully implement the 2014 Edition of CEHRT in time for the 2014 reporting period, while remaining responsive to those stakeholders who could not fully implement 2014 Edition CEHRT through no fault of their own.

Your letter asked us to finalize the rule as quickly as possible and to consider additional changes to the EHR Incentive Program. The comment period for the proposed rule ended on July 21, 2014, and we received over one thousand comments on the rule during the comment period.

Thank you for your interest in the EHR Incentive Program. Please do not hesitate to contact me with any further concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner

*Administrator*

Washington, DC 20201

SEP 12 2014

The Honorable Chris Stewart
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stewart:

Thank you for your letter regarding the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. We appreciate receiving feedback on the program, and we are always seeking ways to improve the EHR Incentive Program.

As noted in your letter, the EHR Incentive Program helps both beneficiaries and providers by advancing the use of Certified Electronic Health Record Technology (CEHRT) to transform health care delivery and improve patient outcomes. We remain cognizant of stakeholder concerns like those cited by your constituents, and we strive to balance those concerns with moving the program forward efficiently.

In an effort to grant more flexibility to providers who have experienced issues that affect their ability to fully implement 2014 Edition CEHRT and attest to meaningful use, we recently issued a final rule that provides additional relief for 2014 (*Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition*, 79 Fed. Reg. 52,910 [September 4, 2014]). This rule allows eligible professionals, eligible hospitals, and critical access hospitals to continue to use 2011 Edition CEHRT or a combination of 2011 Edition and 2014 Edition CEHRT for the EHR reporting periods in CY 2014 and FY 2014, respectively, if they are not able to fully implement 2014 Edition CEHRT for a full EHR reporting period in 2014. We believe these options balance the need to move the EHR Incentive Program forward, especially for those providers and vendors who undertook great effort and expense to fully implement the 2014 Edition of CEHRT in time for the 2014 reporting period, while remaining responsive to those stakeholders who could not fully implement 2014 Edition CEHRT through no fault of their own.

Your letter asked us to finalize the rule as quickly as possible and to consider additional changes to the EHR Incentive Program. The comment period for the proposed rule ended on July 21, 2014, and we received over one thousand comments on the rule during the comment period.

Thank you for your interest in the EHR Incentive Program. Please do not hesitate to contact me with any further concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



Administrator
Washington, DC 20201

SEP 12 2014

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. We appreciate receiving feedback on the program, and we are always seeking ways to improve the EHR Incentive Program.

As noted in your letter, the EHR Incentive Program helps both beneficiaries and providers by advancing the use of Certified Electronic Health Record Technology (CEHRT) to transform health care delivery and improve patient outcomes. We remain cognizant of stakeholder concerns like those cited by your constituents, and we strive to balance those concerns with moving the program forward efficiently.

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Thank you for your interest in the EHR Incentive Program. Please do not hesitate to contact me with any further concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner

TOM RICE

7TH DISTRICT, SOUTH CAROLINA

COMMITTEE ON THE BUDGET

COMMITTEE ON SMALL BUSINESS

COMMITTEE ON TRANSPORTATION
AND INFRASTRUCTURE



Congress of the United States
House of Representatives
Washington, DC 20515-4007

July 18, 2014

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PEE DEE REGIONAL OFFICE:
1831 WEST EVANS STREET
SUITE 300
FLORENCE, SC 29501
TEL: (843) 679-9781
FAX: (843) 679-9783

www.rice.house.gov

Marilyn Tavenner
Administrator Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

OESS
072420144023
DUE -8-7-14

Dear Administrator Tavenner:

We write today to express our concerns regarding implementation of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, and to share with you concerns we have been hearing from district stakeholders.

While we support CMS's efforts to advance the use of Health Information Technology (HIT) and acknowledge the benefits of EHR in transforming health care delivery, we are concerned that the pace and scope of requirements for health care professionals and hospitals continues to be a barrier to widespread adoption and program success.

We appreciate that CMS acknowledged and addressed the need for increased flexibility in 2014 by issuing its proposed rule on May 31, 2014. However, the extremely late release of the proposed rule likely limits its benefit for providers, and we urge you to also extend program flexibility to Fiscal Year 2015 (for hospitals) and calendar year 2015 (for physicians). Specifically, we ask that CMS shorten the meaningful use reporting period from 365 days to 90 continuous days for 2015 to give providers a fairer chance to meet program requirements, obtain any remaining incentive payments, and avoid significant payment penalties. This additional flexibility is necessary to allow the needed time to safely and effectively install and implement 2014 certified HIT software, train clinicians and staff on the creation, use and transmission of EHRs across medical settings, and to meet the more stringent metrics required in the reporting period.

Additionally, we urge CMS to modify current requirements of Stage 2, which make program success for health care professionals and providers contingent upon factors outside of their control. For example, certain program objectives require that large amounts of clinical data be sent from one clinical setting to another (e.g. from a hospital to a skilled nursing facility), however a transmitting provider often cannot find other providers ready to receive the information electronically. Providers are also held accountable for patient actions, such as using a portal to access health information or sending a secure message. While progress is being made in these areas, the current rules make unwarranted assumptions about the level of information

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JUL 24 2014

OSORA, DIVISION OF
CORRESPONDENCE MANAGEMENT

TOM RICE

7TH DISTRICT, SOUTH CAROLINA

COMMITTEE ON THE BUDGET

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House of Representatives
Washington, DC 20515-4007

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exchange that is possible by specifying the “view, download, and transmit” and “transitions of care” requirements that are beyond the capacity of today’s HIT exchange infrastructure.

Finally, we urge CMS to finalize its proposed rule quickly in order to provide needed certainty for health care professionals and providers who are investing significant time and resources in order to meet requirements.

Thank you in advance for your consideration of our request. We remain committed to working with you to enhance the requirements of the program and look forward to your reply. Should you have any questions regarding this request, please do not hesitate to contact Brianna Hewett in my office at (202) 225-9895 or by email at brianna.hewett@mail.house.gov.

Sincerely,

Tom Rice
Member of Congress

Chris Stewart
Member of Congress

Tom Price
Member of Congress

Congress of the United States
Washington, DC 20515

July 28, 2010

*** RECEIVED ***
Jul 29, 2010 08:32:38 WS# 20
OSNUM: 072920101001
OFFICE OF THE SECRETARY
CORRESPONDENCE
CONTROL CENTER

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

We are writing to express our opposition to the content, or lack thereof, that the Department of Health and Human Services (HHS) has placed on HealthCare.gov, the new web portal established under the *Patient Protection and Affordable Care Act* (PPACA).

While we have supported similar web portal proposals to be used as consumer information and transparency tools, we never envisioned it as a way to use taxpayer funds to promote political ideology masquerading as "facts." We take issue with the Administration's claim during a meeting with Republican staff on July 7, 2010, that the content chosen for the web portal was simply for "consumer education," as so far the information presented is all one-sided. We are concerned that HHS is misusing its regulatory powers to influence the debate, and we believe it is not HHS' proper role to limit information to only what the Administration sees as positive benefits of PPACA, while leaving out key information that will have dramatic effects on the lives of Americans.

We provide the following examples as evidence of our claim:

- The banner at the top of every page says "health care is getting better." which is a purely subjective statement.
- Information about Medicare Advantage plans is noticeably absent. The only information listed under "Find Insurance Options" is information on Medigap plans (like the kind AARP offers), Medicaid, state-based options, and local facilities that provide "reduced priced care". American seniors who want to learn "more about insurance for benefits that are not covered by Medicare" deserve to know all of their options.
- The warning label that pops up for insurance searches in 45 states says, "A quick note about individual insurance: Unless you live in New York, New Jersey, Massachusetts, Vermont, or Maine, be aware that the current marketplace creates several challenges for the consumer." The five states listed are those with guaranteed-issue laws. The statement is certainly biased against states (and insurers) that do not mandate guaranteed-issue. While it is true that coverage may not be guaranteed through the individual insurance market, the webpages that contain this statement fail to contain

any follow up statements about other available options in these states or why the state has chosen to not mandate guaranteed-issue.

- Under the timeline provided by the Administration, there is a graphic of a briefcase overflowing with money, labeled "Stopping Overpayments to Big Insurance Companies" accompanied by a slide titled "Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage." Not only is the graphic biased and over the top in its vilification of insurers, but it also fails to be accompanied by information from CMS' Actuary warning that more than half of seniors will lose access to their Medicare Advantage plans due to over \$200 billion in cuts under PPACA.¹
- The website claims, under the "Strengthening Medicare" tab "The life of the Medicare Trust Fund will be extended to at least 2029, a 12-year extension..." This statement is completely false, as these new Medicare cuts are not being used to improve the program's solvency, but instead are being used to offset the massive new entitlement spending and government programs. According to CMS' Actuary, "in practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."² The truth is either you're extending the life of Medicare or you're paying for the bill. You can't claim both and CBO agrees.³

Items that were noticeably left off the HealthCare.gov web portal but certainly fall under the definition of "consumer education" include:

- No references to tax increases (among other negative aspects of PPACA) on the timeline.
- No warning that consumers should stay away from high-costs plans or be subject to the "Cadillac Tax."
- No mention that there will not be enough funding for the new high risk pools to run through 2014 – as both CBO and CMS' Actuary have found.^{4,5}

¹ See Memorandum from Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended* (April 22, 2010).

² See *id.*

³ See Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable Jeff Sessions (January 22, 2010).

⁴ See Memorandum from Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended* (April 22, 2010). Letter to Senator Michael B. Enzi from Douglas W. Elmendorf, Director, Congressional Budget Office (June 21, 2010).

⁵ See Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable Michael B. Enzi, Ranking Member of Senate Health, Education, Labor and Pensions Committee (June 21, 2010).

- No warning under the "Understand the New Law" tab that over 51% of employees will be in plans without "grandfathered" status, as employers will be forced to change their plans to comply with PPACA.⁶
- No information about private entities that offer assistance in picking a personalized plan, such as certified state-licensed independent insurance agents and brokers.
- No information about providers that still take Medicaid and/or Medicare.
- No information about, or restrictions being placed on, Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), etc. through PPACA.

Therefore, we respectfully request that HHS act as a responsible steward of taxpayer dollars and remove all factual inaccuracies, misleading statements, and subjective one-sided information, while adding essential consumer education information, whether positive or not.

We appreciate your attention to this issue and look forward to your prompt response.

Yours truly,

W. Cade Abin

[Signature]

Doug Johnson

David Price

Peter Griffith

[Signature]

Rodney Alexander

Patrick McHenry

Ren Paul

Steve King

Jeff Jarvis

[Signature]

⁶ See 75 FR 34538, *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act* (June 17, 2010).

Tom Graves GA-9

~~Lynn [unclear]~~

Don Manzullo

~~Jamie [unclear]~~

Bill [unclear] FLIS

~~Steve [unclear]~~

Bob [unclear]

~~John Flynn~~

Ralph Hall 20x-4

~~John Klein~~

Don [unclear] CA-48

~~Kalvin E. Jatta~~

Frank [unclear]

~~K. [unclear]~~

Don [unclear] 5

~~John A. [unclear]~~

Charles [unclear] MS-6

~~Howard P. "Beck" [unclear]~~

Joseph [unclear]

~~John [unclear]~~

Pete Olson

~~Lamar Smith~~

Joe Wilson

~~Bob [unclear]~~

K. Murchett

~~Jeff [unclear]~~

Carl Brown

~~C. [unclear]~~

Jo Hensarling

~~Carl Kingston~~

Dean Heller

~~[unclear] FL~~

E. Pearson

~~Foy [unclear]~~

Blair [Signature]
Peterson

Jeff Miller
Bauer

Mike Coffey

Nichole Bachman

Jeff [Signature]

Denny Redberg

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Healthcare.gov letter

1. Todd Akin
2. Tom Price
3. Gary Miller
4. Steve King
5. John Campbell
6. Jason Chaffetz
7. Lynn Westmoreland
8. Tom Graves
9. Don Manzullo
10. Bill Posey
11. Rob Bishop
12. Ralph Hall
13. Trent Franks
14. Dan Burton
15. Roscoe Bartlett
16. Phil Roe
17. Joe Wilson
18. Mike Conaway
19. Parker Griffith
20. Doug Lamborn
21. Jack Kingston
22. John Mica
23. Michele Bachmann
24. Joe Pitts
25. Kevin Brady
26. Lamar Smith
27. Jeb Hensarling
28. Kenny Marchant
29. Cynthia Lummis
30. Rodney Alexander
31. John Fleming
32. Patrick McHenry
33. Charles Boustany
34. Jeff Miller
35. Erik Paulsen
36. Steven LaTourette
37. Roy Blunt
38. Mike Coffman
39. Spencer Bachus
40. Howard "Buck" McKeon
41. Ron Paul
42. Thad McCotter
43. Pete Sessions
44. John Duncan

45. Paul Broun
46. Geoff Davis
47. Todd Tiahrt
48. Dean Heller
49. Blaine Luetkemeyer
50. Pete Olson
51. John Kline
52. Robert Latta
53. Cliff Stearns
54. Dennis Rehberg

117 Cannon HOB Washington, DC 20515
(202) 225-2561 / (202) 225-2563 Fax

**Office of Congressman
W. Todd Akin**

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Fax

To: HHS-OLA From: Lauren Ellis

Fax: 202-690-7380 Pages: 5

Phone: _____ Date: 7/28/10

Re: Healthcare.gov portal CC: _____

Urgent For Review Please Comment Please Reply Please Recycle

Please feel free to contact me at 202-225-2561
if you have any questions.

FAXED
07/28/10 Dr. R...

Reassign to Office of Health Reform.

CHARLIE MELANCON
3RD DISTRICT, LOUISIANA

COMMITTEE ON ENERGY
AND COMMERCE

COMMITTEE ON
SCIENCE AND TECHNOLOGY
Jul 29, 2010 12:09:04 WS# 20
OSNUM: 072920101014
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Congress of the United States House of Representatives

Washington, DC 20515

July 21, 2010

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423 LAFAYETTE STREET, SUITE 107
HOUMA, LA 70360
(985) 876-3033
124 EAST MAIN STREET
SUITE 220-A
NEW IBERIA, LA 70560
(337) 367-8231

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius,

As you continue to improve the health care reform insurance web portal (portal) unveiled on July 1 as required by the Patient Protection and Affordable Care Act (PPACA), we strongly encourage you to include the ability for consumers to contact certified, state-licensed independent health insurance agents and brokers for assistance when comparing coverage options. It is important that the consumer's option to contact independent and state licensed health insurance agents and brokers be included no later than October 1 when the portal is scheduled to be finalized.

When crafting both the PPACA and its House-passed companion measure, H.R. 3962, the Affordable Health Care for America Act, the Congress made sure to explicitly include provisions to give consumer access to independent and state licensed health insurance agents and brokers in a reformed health insurance marketplace, both inside and outside health insurance exchanges. These professionals are certified, licensed, and trained to help individuals and employers purchase appropriate coverage and utilize benefits effectively. Because the development of the portal serves as a precursor of state-based health insurance exchanges, it is imperative that the portal specifically include access to the services of independent and state licensed health insurance agents and brokers.

The portal and planned call center will provide individuals and small businesses with basic coverage and price information in a centralized location, but will not provide the personal service and plan policy knowledge that distinguishes independent and state licensed health insurance agents and brokers. These professionals provide individuals and small businesses with information and advice about all products in the marketplace, so that consumers can adequately compare the value and appropriateness of every health insurance option available to them. Given that independent and state licensed health insurance agents and brokers are already helping millions of individuals and small businesses purchase health insurance coverage nationally, they could provide this outreach and enrollment assistance through the portal at virtually no cost to the federal government.

It is our belief that consumers will benefit from this arrangement and will respond positively to the new portal method of purchasing health insurance if they are able to access the personalized service of an insurance agent or broker. Thank you in advance for considering our comments.

Sincerely,

Clara Blum

Henry

John Doe

Klaus Bachmann

Ron Paul

John C. Doe

Baron P. Hill

Sam Gold

Carrie Smith

Bob Jones

John Brown

Lynn Jenkins

Howard Cole

John Smith

Ken Carter

Tom Johnson

Vernon J. Ehlert

Rob Bauer

Ch. Bentley

Leonard L. Beaudell

John A. Baccieri

Mike Cohen

Joe Wilson

Mike Paul

T. Bels

Web portal sign-on letter:

- 1) Lee Terry
- 2) Ron Paul---Norman (203)
- 3) Rick Boucher---Chris Davis (2187)
- 4) John Sullivan---John Rainbolt (434)\
- 5) Coble---Jane Miller (2468)
- 6) Blackburn---Cara (217)
- 7) Boswell---Katy (1427)
- 8) Hill---Joel (223)
- 9) Barrow---Hill (213)
- 10) Tom Latham---Jake (2217)
- 11) Schock---Margie (509)
- 12) Coffman---Steve (1508)
- 13) Ross---Kate (2436)
- 14) Burgess---JP (229)
- 15) T.Price---Emily (424)
- 16) Ehlers---Rachel (2182)
- 17) Petri---Kevin (2462)
- 18) Calvert---Chris (2201)
- 19) Adrian Smith---Josh (503)
- 20) Joe Wilson---Heather (212)
- 21) Boccieri---Justin (1516)
- 22) Boustany---Mike Thompson (1117)
- 23) Lynn Jenkins---Emily (130)
- 24) Inglis---Chris (100)



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Anna G. Eshoo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Eshoo:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule, titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" (80 FR 41685), was issued on July 8, 2015, with a 60-day comment period that ended on September 8, 2015. We will carefully consider all comments received during the comment period as we develop the final rule.

We appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. We will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD, MSc".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Diana DeGette
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeGette:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Cathy McMorris Rodgers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rodgers:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD, MSc".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Michael C. Burgess M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD, MSc".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Ed Whitfield
U.S. House of Representatives
Washington, DC 20515

Dear Representative Whitfield:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Bill Pascrell Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pascrell:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Joe Barton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barton:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD".

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Gus Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Susan W. Brooks
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brooks:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Pete Olson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Olson:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Peter Welch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Welch:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Larry Bucshon M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Billy Long
U.S. House of Representatives
Washington, DC 20515

Dear Representative Long:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Patrick Meehan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meehan:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Linda Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Doris Matsui
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Tony Cardenas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cardenas:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Vern Buchanan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Tom Price M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Kurt Schrader
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schrader:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator

Washington, DC 20201

The Honorable Peter J. Roskam
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roskam:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



Deputy Administrator

Washington, DC 20201

SEP 11 2015

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



Deputy Administrator

Washington, DC 20201

SEP 11 2015

The Honorable Robert E. Latta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Latta:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



Deputy Administrator

Washington, DC 20201

SEP 11 2015

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



Deputy Administrator

Washington, DC 20201

SEP 11 2015

The Honorable Robin L. Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kind:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



SEP 11 2015

Deputy Administrator
Washington, DC 20201

The Honorable Jackie Speier
U.S. House of Representatives
Washington, DC 20515

Dear Representative Speier:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator



Deputy Administrator

Washington, DC 20201

SEP 11 2015

The Honorable Dave Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

Thank you for your letter regarding our proposal in the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) proposed rule to establish payment for biosimilar biological products based on the average sales price of all biosimilar biological products that rely on a common reference product's biologics license application. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Patrick Conway, MD, MSc
Acting Principal Deputy Administrator

U. S. House of Representatives
Washington, D. C. 20515

August 4, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Acting Administrator Slavitt,

We write to express our serious concerns with provisions relating to biosimilar reimbursement in the Centers for Medicare and Medicaid Services' (CMS) 2016 Medicare Physician Fee Schedule proposed rule.

Specifically, we are concerned with the agency's proposal to assign all biosimilars of a single reference product one Healthcare Common Procedure Coding System (HCPCS) code and to reimburse biosimilars with the same HCPCS code based on the weighted average of their average sales price under Medicare Part B.

In this proposal, CMS treats biosimilars as if they are generic drugs. As a primary matter, it is important to recognize that traditional small-molecule pharmaceuticals and biologics are fundamentally different in their development, manufacture and chemical makeup. A biologic is a large, complex molecule, which is grown in living systems such as a microorganism, a plant or animal cell.

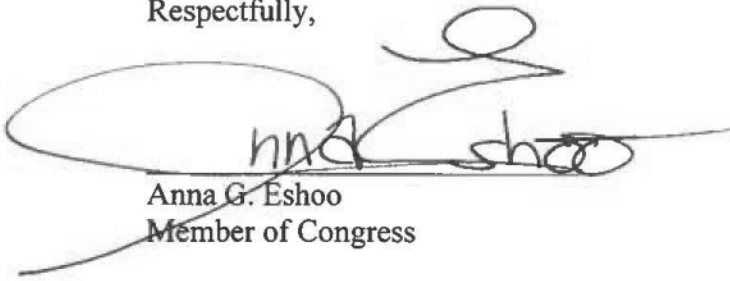
These differences are acknowledged by the statutory provisions establishing the biosimilars pathway and by the Food and Drug Administration (FDA).

Section 1847A of the Social Security Act ("SSA"), 42 U.S.C. § 1395w-3a states that the calculation for reimbursing biosimilars shall be made separately, such that each biosimilar will have its own unique payment rate and unique HCPCS code. This language reflects congressional intent to encourage a vibrant biosimilars market and we urge you to enact a final payment rule that provides each biosimilar with a unique code.

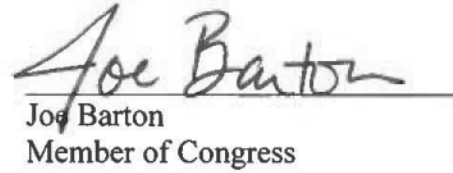
Thank you for your attention to this highly important issue and we look forward to your timely response. If you need further assistance, please contact Hannah Murphy in

Congresswoman Anna Eshoo's office at Hannah.Murphy@mail.house.gov or Krista Rosenthal in Congressman Joe Barton's office at Krista.Rosenthal@mail.house.gov.

Respectfully,



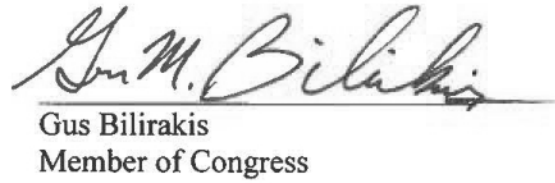
Anna G. Eshoo
Member of Congress



Joe Barton
Member of Congress



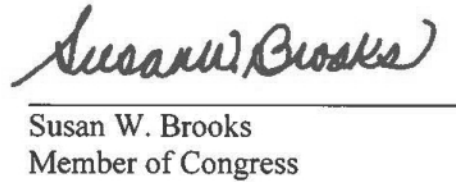
Diana DeGette
Member of Congress



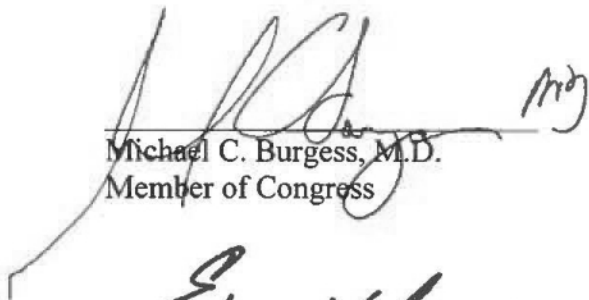
Gus Bilirakis
Member of Congress



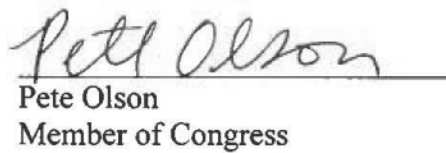
Cathy McMorris Rodgers
Member of Congress



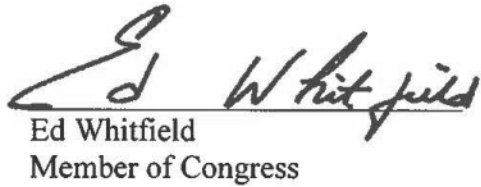
Susan W. Brooks
Member of Congress



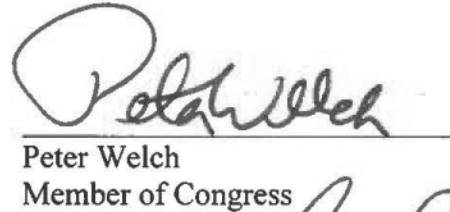
Michael C. Burgess, M.D.
Member of Congress



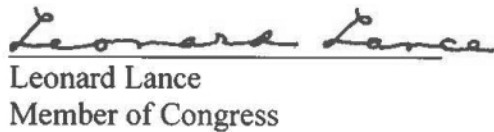
Pete Olson
Member of Congress



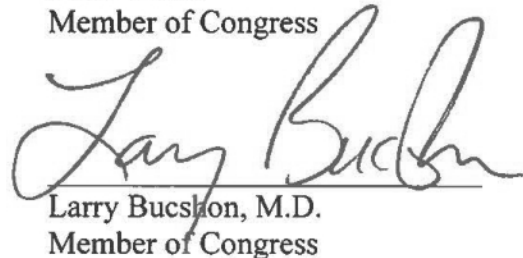
Ed Whitfield
Member of Congress



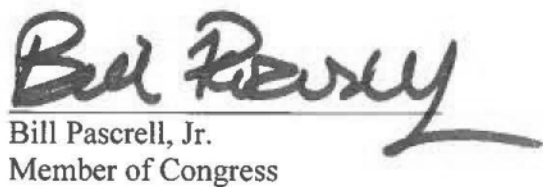
Peter Welch
Member of Congress



Leonard Lance
Member of Congress



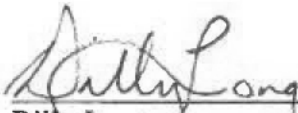
Larry Bucshon, M.D.
Member of Congress

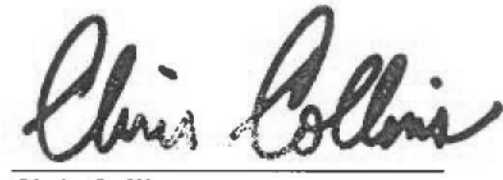


Bill Pascrell, Jr.
Member of Congress



Bill Johnson
Member of Congress

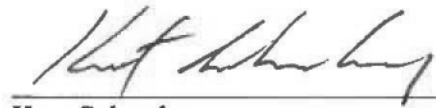

Billy Long
Member of Congress

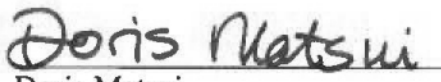

Chris Collins
Member of Congress

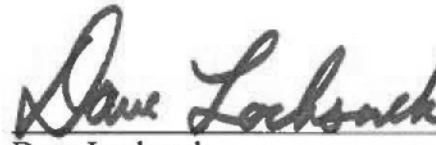

Patrick Meehan
Member of Congress

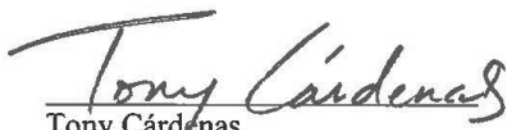

Brett Guthrie
Member of Congress

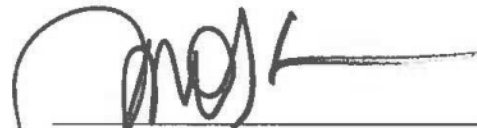

Linda Sánchez
Member of Congress

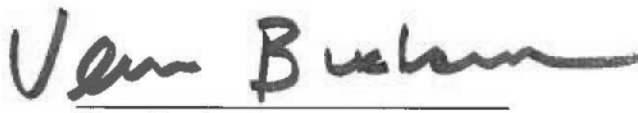

Kurt Schrader
Member of Congress

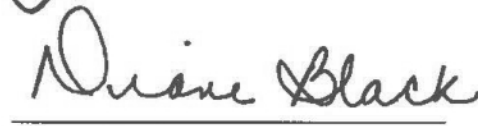

Doris Matsui
Member of Congress

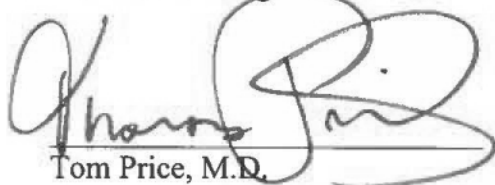

Dave Loebsack
Member of Congress



Tony Cárdenas
Member of Congress


Peter J. Roskam
Member of Congress


Vern Buchanan
Member of Congress


Diane Black
Member of Congress


Tom Price, M.D.
Member of Congress

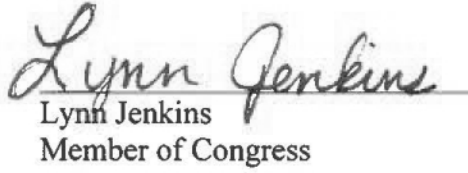

Devin Nunes
Member of Congress



Robert E. Latta
Member of Congress



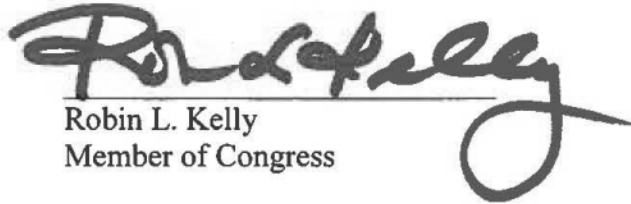
Ron Kind
Member of Congress



Lynn Jenkins
Member of Congress



Jackie Speier
Member of Congress



Robin L. Kelly
Member of Congress



OCT - 6 2011

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington DC 20515

Dear Representative Kind:

Thank you for your letter regarding implementation of the competitive bidding program and accreditation standards for suppliers who provide equipment and supplies used to deliver negative pressure wound therapy (NPWT). The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

I want to assure you that we are considering this matter carefully. The statute requires that we phase in items under the competitive bidding program beginning with high cost or high volume items, such as NPWT. However, the safety and well-being of Medicare patients for whom NPWT is prescribed is critical regardless of the payment methodology used to reimburse suppliers for furnishing NPWT equipment and supplies.

We are aware that the Food and Drug Administration (FDA) has issued guidance to health care professionals and patients regarding NPWT. We have also received, and are reviewing, the draft NPWT standards developed by the Alliance for Wound Care Stakeholders. We are evaluating the FDA guidance and recommended standards, and are considering whether enhancements to the quality standards are needed to ensure that suppliers can furnish this equipment safely in all areas of the country.

As you may know, section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the Secretary to establish and implement quality standards for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). All DMEPOS suppliers (except for exempted professionals and other persons as specified by the Medicare Improvement for Patients and Providers Act of 2008) must comply with the Medicare program's supplier standards and quality standards to become accredited.

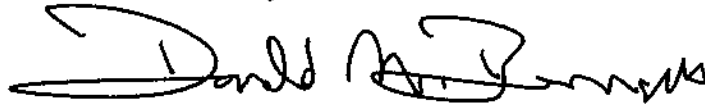
We note that the current quality standards already require suppliers to educate beneficiaries and caregivers on the safe use of equipment including infection control practices and identifying potential hazards. In addition, as part of their required product safety program, suppliers are required to identify, report, and investigate any incident, injury, or infection, and to identify whether changes in their programs are needed. The current quality standards also require that suppliers provide only durable medical equipment (DME) and other items that meet applicable FDA regulations and medical device effectiveness and safety standards. Of course, a supplier cannot continue to furnish items and services to Medicare beneficiaries if the supplier fails to remain accredited to provide safe, quality products and services in accordance with these and other quality standards currently in place. Suppliers that submit bids under the competitive bidding program must be accredited at the time they submit their bids.

Page 2 – The Honorable Ron Kind

Although the quality standards are designed to ensure that equipment is properly and safely furnished and maintained, the quality standards do not address clinical services that are not included in the Medicare DME benefit. For example, the FDA has provided recommendations to healthcare practitioners for reducing risks such as bleeding and infection related to NPWT. The Medicare benefit for furnishing DME for use in the home does not extend to clinical services furnished by doctors, nurses, and other clinicians related to NPWT. These clinicians are responsible for caring for the patient in accordance with other Federal and State licensure and other professional requirements. Suppliers who furnish DME do so in response to detailed written orders from physicians and practitioners, and must furnish the equipment in compliance with the clinician's order. We will make every effort to ensure that suppliers continue to do so under the Medicare program.

I appreciate your interest in this important issue, as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick". The signature is fluid and cursive, with a large initial "D" and "B".

Donald M. Berwick, M.D.



OCT - 6 2011

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington DC 20515

Dear Representative Price:

Thank you for your letter regarding implementation of the competitive bidding program and accreditation standards for suppliers who provide equipment and supplies used to deliver negative pressure wound therapy (NPWT). The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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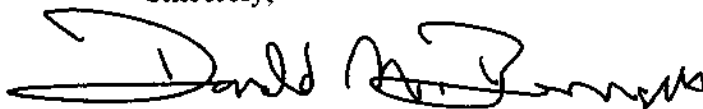
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Page 2 – The Honorable Tom Price

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Donald M. Berwick, M.D.



OCT - 6 2011

Administrator
Washington, DC 20201

The Honorable Michael C. Burgess , M.D.
U.S. House of Representatives
Washington DC 20515

Dear Representative Burgess:

Thank you for your letter regarding implementation of the competitive bidding program and accreditation standards for suppliers who provide equipment and supplies used to deliver negative pressure wound therapy (NPWT). The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

I want to assure you that we are considering this matter carefully. The statute requires that we phase in items under the competitive bidding program beginning with high cost or high volume items, such as NPWT. However, the safety and well-being of Medicare patients for whom NPWT is prescribed is critical regardless of the payment methodology used to reimburse suppliers for furnishing NPWT equipment and supplies.

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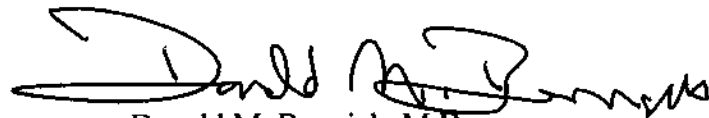
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Page 2 – The Honorable Michael C. Burgess, M.D.

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I appreciate your interest in this important issue, as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

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Donald M. Berwick, M.D.



RECEIVED
AUG 05 2011
OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Fax Cover Sheet
Congressman Tom Price
6th District of Georgia
403 Cannon House Office Building
Washington, DC 20515
Phone: (202) 225-4501
Fax: (202) 225-4656

To: Administrater Berwick

From: Laura Holland, Office of Tom Price

Comments: _____

Number of Pages including Cover Sheet: 5

Congress of the United States
Washington, DC 20515

August 4, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Berwick:

As implementation for the Competitive Bidding program continues, we urge that the Centers for Medicare and Medicaid Services (CMS) take steps to guarantee patient access to quality products, particularly complex wound care products. Specifically, we ask that CMS implement Negative Pressure Wound Therapy (NPWT) accreditation standards for suppliers who provide NPWT to Medicare Part B beneficiaries.

Appropriate access to Negative Pressure Wound Therapy (NPWT) is of crucial benefit to Medicare beneficiaries with chronic and complex wounds in both institutional and home care settings. Most importantly, NPWT has made it possible for even the most compromised wound care patients to heal in the home, reducing the need for treatment in more costly institutional settings.

Experienced NPWT providers have for years delivered this highly complex product safely to patients in all care settings, particularly the home. As you know, the safe and effective use of these sophisticated therapeutic devices in the home requires a higher level of training and support than is required for simple functional products such as walkers, bed frames, and crutches. Because NPWT products are used frequently to treat wounds occurring in highly compromised patients, failure of the products to work as intended can result in serious health complications, including loss of life and limb.

In a 2010 white paper entitled, "Medical Device Home Use Initiative," the Food and Drug Administration (FDA) acknowledged the increasing trend of patient treatment migrating from institutional settings to home-based settings. Home healthcare, when delivered correctly, can improve quality of life and lower costs for the patient and the healthcare system. With this

change of treatment setting comes a reality that the proper use of products in the home requires detailed instruction for use, as well as training, education, and 24/7 user-support.

The FDA white paper highlights the need for appropriate NPWT accreditation standards which reflect the necessary training, education and 24/7 customer support. Given the complex nature of NPWT devices, we believe it is important that all suppliers of NPWT products participating in the competitive bidding program should meet minimum standards. Recently, the Alliance for Wound Care Stakeholders developed NPWT accreditation standards. We believe these standards can serve as a basis for category standards moving forward.

As a result, if CMS elects to include NPWT products in the second round of Competitive Bidding, we recommend that all bidders be accredited at the time of bid submission. Doing so would be consistent with accreditation requirements in other categories that are already included in the competitive bidding program. Furthermore, NPWT accreditation standards will ensure that submitted bids are valid and reflect the necessary services defined in the accreditation standards.

We look forward to working with you and CMS and look forward to your response on the matter.

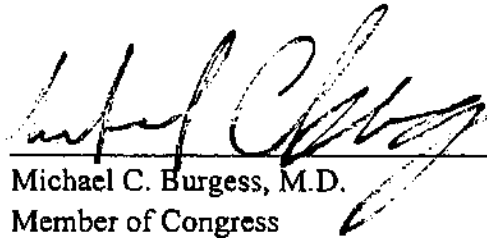
Sincerely,



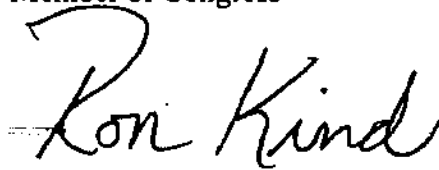
Charles A. Gonzalez
Member of Congress



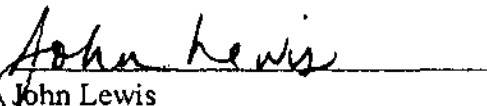
Tom Price
Member of Congress



Michael C. Burgess, M.D.
Member of Congress




Ron Kind
Member of Congress




John Lewis
Member of Congress




Patrick J. Tiberi
Member of Congress

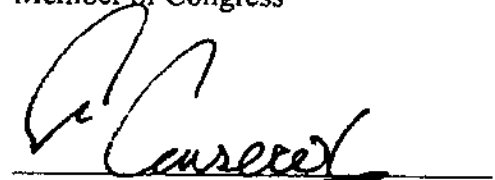

Renee L. Ellmers
Member of Congress

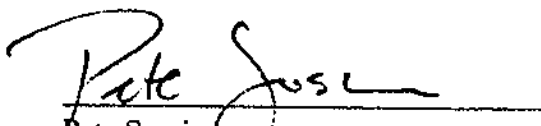

Jim Gerlach
Member of Congress



Betty Sutton
Member of Congress

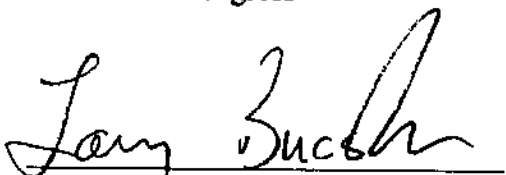

Pete Olson
Member of Congress

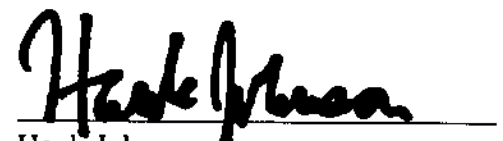

Martin Heinrich
Member of Congress


Francisco "Quico" Canseco
Member of Congress



Pete Sessions
Member of Congress

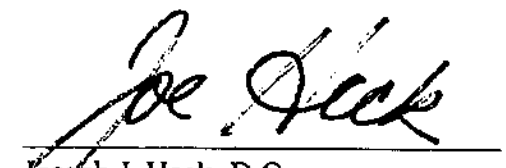

C.W. Bill Young
Member of Congress

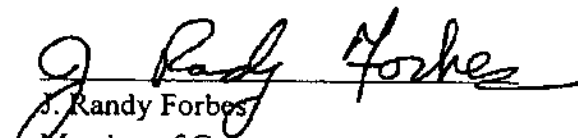

Larry Bucshon, M.D.
Member of Congress


Hank Johnson
Member of Congress


H. Morgan Griffith
Member of Congress


Marsha Blackburn
Member of Congress


Joseph J. Heck, D.O.
Member of Congress


J. Randy Forbes
Member of Congress

Erik Paulsen

Erik Paulsen
Member of Congress

Brian P. Bilbray

Brian P. Bilbray
Member of Congress

John D. Dingell

John D. Dingell
Member of Congress

Heath Shuler

Heath Shuler
Member of Congress

Greg Walden

Greg Walden
Member of Congress

Ed Pastor

Ed Pastor
Member of Congress

Joe Courtney

Joe Courtney
Member of Congress

Joe Pitts

Joe Pitts
Member of Congress



SEP - 4 2014

Administrator
Washington, DC 20201

The Honorable Thomas Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the proposed change to the process for adopting misvalued code recommendations in the 2015 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The 2015 PFS proposed rule was issued on July 3, with a 60-day comment period that ended on September 3. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include a summary of the comments and our responses in the final regulation. We typically publish the PFS final rule on or about November 1 each year.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

August 4, 2014

Marilyn B. Tavenner, MHA, BSN, RN
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

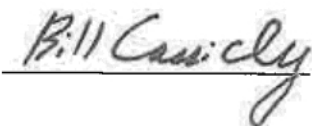
We are writing to follow up on our April 17 letter regarding improving the transparency and stakeholder input for changes made to physician payments through the rule-making process. In particular, we raised concerns that the current processes lack transparency and deprive health care providers and the recipients of their services the opportunity to fairly and meaningfully participate in the Agency's rulemaking.

We commend CMS for its proposed reform to limit changes in the final rule to issues discussed in the proposed rule, as this will lead to greater transparency, deliberation and a more thoughtful public policy. CMS acknowledged these concerns and made significant progress towards increased transparency by recommending that changes to service code definitions and valuations be included in Physician Fee Schedule (PFS) *proposed* rules, rather than final rules. Specifically, in the CY 2015 PFS Proposed Rule, CMS states, "we are proposing to modify our process to make all changes in the work and MP RVUs and the direct PE inputs for new, revised and potentially misvalued services under the PFS by proposing the changes in the proposed rule, beginning with the PFS proposed rule for CY 2016." In making this recommendation, CMS highlights previous rulemaking in which comments provided subsequent to promulgation of a PFS final rule (and establishment of final values for certain codes) would have been useful if the process had allowed for such comment in response to the proposed rule instead.

Among other benefits, this proposal will ensure that providers have a sufficient opportunity to review and provide public comment on new values and price inputs for services *before* new rates are established as final. However, we cannot understand why CMS has chosen to delay this important policy reform until the CY 2016 PFS rulemaking cycle. There is no reason to delay these important reforms and subject a certain providers to the same opaqueness and lack of transparency in the 2015 PFS Final Rule under a process CMS acknowledges to be flawed. ***As such, we urge CMS to implement its proposed transparency changes immediately and for the CY 2015 PFS rulemaking cycle.*** This would ensure equitable treatment and transparency for *all* providers within the Physician Fee Schedule immediately.

Again, we thank you for your consideration in this regard and urge the agency to adopt its recommended PFS transparency policy immediately.

Sincerely,


Bill Cassidy


Paul G. Gillingham

Thomas Prid

John Miller

Pete Olson

Michelle Bryan Hussam

Brett Guthrie

Chris R. Lee

Chris Pappas

Mr Brinkley

Ken Neault

Chris Collins

Chris

Leovara Lance

Nasha Blackburn

John Fleming

Doug LaMalfa

Sen. M. Bilirici

Alan Nunnlee

C.W. Bonstaph

Bill Johnson

Mac, M.D.

Vu Zuh

E. Whitfield

J. Rody Forbes

Ed Wilson

Jim Matheson

Patrick P. Murphy

J. K. Boyer M.D.

Steve Crot

Quinn Black

Tim Murphy

Tim Hoff



Administrator
Washington, DC 20201

SEP 24 2008

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Mr. Price:

Thank you for your letter regarding the fiscal year (FY) 2009 Hospital Inpatient Prospective Payment System (IPPS) final rule. I apologize for the delay in this response.

In the FY 2008 IPPS final rule with comment period, published on August 22, 2007, the Centers for Medicare & Medicaid Services (CMS) formally adopted as final policy a phase-out of the capital IPPS indirect medical education (IME) adjustment over a 3-year period. CMS considered public comments received on this policy before and after publication of the FY 2008 IPPS final rule with comment period, and again during the comment period for the FY 2009 IPPS proposed rule. The FY 2009 IPPS final rule that was published on August 19, addressed the public comments on this issue but did not contain any further changes to the capital IME policy than those which were finalized in the FY 2008 rule.

For the FY 2008 IPPS proposed rule, CMS conducted a margin analysis which indicated that several classes of hospitals had experienced continuous and significant positive capital IPPS margins over an extended period (FY 1998 through FY 2005). The analysis also showed that the existing capital IPPS payment adjustments for teaching hospitals (i.e., IME) and disproportionate share hospitals were contributing to excessive payment levels for these classes of hospitals.

In the FY 2008 final rule with comment period, we also noted a recommendation from the Medicare Payment Advisory Commission (MedPAC) that CMS seriously reexamine the appropriateness of the existing capital IME adjustment. MedPAC indicated that some reduction in the capital IME adjustment would be consistent with finding that the IME adjustment is set too high.

Consistent with MedPAC's recommendation, we extended the capital IPPS margin analysis to further analyze the experience of teaching hospitals. This analysis demonstrated that teaching hospitals' capital IPPS margins are significantly higher than are comparable non-teaching hospitals' margins. For example, for the period covering FY 1998 through FY 2005, teaching hospitals realized aggregate positive capital IPPS margins of 11.6 percent, compared to a positive margin of just 0.3 percent for non-teaching hospitals.

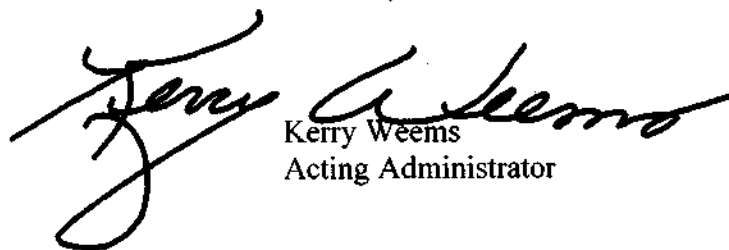
In light of MedPAC's recommendation and the margins analysis, we concluded that the relatively high and persistent positive margins for teaching hospitals under the capital IPPS indicated the capital IME adjustment payable to teaching hospitals is unnecessary, and

that it was appropriate to eliminate this adjustment. At the same time, we believed we should mitigate abrupt changes in payment policy, and that we should provide time for hospitals to adjust to changes in the payments they can expect under the IPPS. Therefore, in the FY 2008 IPPS final rule, we adopted a policy to phase-out the capital IME adjustment over a 3-year period beginning in FY 2008. Under this transition, there is no change to the capital IME adjustment for FY 2008; the capital IME adjustment is to be reduced by a 50-percent reduction for FY 2009; and the capital IME adjustment will be eliminated for FY 2010 and for later FYs.

Although CMS is not proposing further changes to the capital IME policy, in the FY 2009 IPPS proposed rule, we updated the capital IPPS margin analysis using more recent data which continue to show teaching hospitals are realizing significant positive margins under the capital IPPS. Specifically, in the aggregate, teaching hospitals experienced capital IPPS margins of 12.1 percent in FY 2001, 13.8 percent in FY 2002, 13.2 percent in FY 2003, 11.5 percent in FY 2004, 10.8 percent in FY 2005, and 8.4 percent in FY 2006. This updated margin analysis continues to confirm that the capital IPPS has been providing more than adequate funding for the capital needs of teaching hospitals.

I hope this information is helpful to your understanding of the setting in which we made the FY 2009 reduction to the capital IME adjustment. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry Weems". The signature is fluid and cursive, with a large initial "K" and "W".

Kerry Weems
Acting Administrator

08062008 4057
Due - 8/20/08

Congress of the United States
Washington, DC 20515

July 28, 2008

The Honorable Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Weems:

We are writing regarding a scheduled cut included in this year's proposed rule for the inpatient prospective payment system (IPPS) that significantly affects teaching hospitals across the country. Specifically, your agency has proposed to eliminate the indirect medical education (IME) adjustment in the capital PPS over the course of two years, beginning on October 1, 2008. This policy will result in about \$375 million in aggregate annual losses and subsequently threatens the financial viability of teaching hospitals that serve a high volume of Medicare beneficiaries and provide critical services unavailable elsewhere in communities across the country. Such a policy fails to consider the overall margins of teaching institutions, and does not reflect the appropriate ways these hospitals receive and utilize their capital IPPS payments. Hence, we urge you to withdraw this harmful policy in your FY 2009 final IPPS rule.

While the inpatient PPS is the only payment system in Medicare that does not provide a single payment for total cost (i.e., operating and capital), hospitals have used these payments as if they were a single, combined payment ever since capital cost-based reimbursement ended. As such, hospitals have appropriately made their own decisions to efficiently deploy their financial resources to meet their most urgent needs, as is the intent of the prospective payment system. Therefore, it is inappropriate for your agency to base a decision to eliminate capital IME payments on a capital margin analysis alone, a decision that is further skewed because your analysis ignores the capital expenditure cycle by which hospitals plan and make capital investments. CMS should instead examine Medicare margins across both capital and operating payment systems. Given that the Medicare Payment Advisory Commission found in 2006 that major teaching hospitals faced low overall Medicare margins of 2.8% and other teaching hospitals faced an even

lower margin of -5.4%, unwarranted reductions to these hospitals would have deleterious consequences on the communities they serve.

Furthermore, teaching institutions have inherently higher capital costs when compared to non-teaching hospitals. This is due to the need to have classroom space, extra equipment to train medical residents, basic physical plant requirements (e.g., additional electrical outlets), as well as more sophisticated physical plant needs such as advanced electrical, heating, and cooling systems to support (and back-up in emergencies) this technology. As in the operating PPS, the capital IME adjustment recognizes that teaching hospitals must meet the demands of treating sicker patients, as well as meet the financial demands of operating emergency and trauma care, providing highly specialized services, and treating uninsured patients.

It is for these reasons, that it is imperative that your agency withdraw this harmful policy in the FY 2009 final IPPS regulation.

Sincerely,

Jim Marshall

Peter T. King

Cale E. Cilles

Edward J. Markey

Don Young

Danmy H. Davis

Eliot L. Engel

David Price

Paul C. Kujowski

Rick Boucher

Rosa d. De Laura

Jerry Moran

Richard Shea

Alouy

Niki Trovaz

Elijah E. Zimmerman

Fred Apito

Earl Blumstein

Lynn Woodsey

Henry A. Wafman

Howard L. Bermer

Donald Myzelle

Laura Piersson

John F. Tunney

Sam Moran

Ray L. Ackerson

Sam Baker

Barney Frank

Dave Stokes

James T. Welch

Cliff King

Art Edwards

Marion Berry

Bill Foster

Art Fattah

~~Murray White~~

Gene Brown

Phil English

Joseph Kalle

W. M. Young

Ben Delahunt

W. A. M.

Louise M. Slaughter

Ed Pastor

Lamar Smith

Anna DeWitt

John P. Minter

J. H. Mott

Janet Ham

Tommy Balch

Bill Pascrell Jr.

Nyde S. V. Jr.

T. H. H.

Anna DeWitt

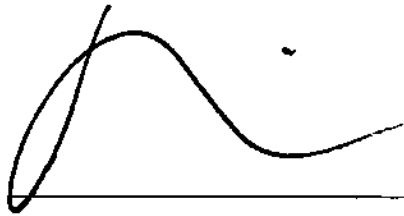
Henry E. Mitchell

Jim WA

Phil Hane

Robin Emanuel

Luis Capps



Mary Dono Mack

Patricia Tiller

Rick Loren

Charles W. Det

Milt Doyle

C. A. Dutch Ruppertberger

Michael & Michael

Ralph Murre

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Jan Selukowsky

Jim McDemott

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Allan Boyer

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Stephen Patrick Jones

Konrad Blum

Sam Farn

Steve Kagen, M.D.

Jordan Levin

Kendra J. Dandley

Vic Snyder

Delia Wasserman Schuff

Kirsten E. Tillbrand

John Peterson

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Arthur Davis

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Anthony Taylor

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Tracy

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DeRube

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Patsy

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Conrad

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Tim Wirth

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Mamun Dindig

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E Cotton

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Muff Lampson

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J. Buttiford

Q. O.

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Shelley Berkeley

Mad. Udall

Peter O. Keady

Geo. E. Leman

~~John~~

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Meluhomyn

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John Costello

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Zee Fob

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Chapman

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John

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Jerry Costello (IL)
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Zoe Lofgren (CA)
Bobby Scott (VA)

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Mike Simpson (ID)

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Peter Welch (VT)

John Olver (MA)
Russ Carnahan (MO)
Keith Ellison (MN)
John Yarmuth



Administrator
Washington, DC 20201

SEP 12 2014

The Honorable Tom Price, MD
House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding Medicare coverage and coding for the NovoTTF-100A Therapy system approved by the Food and Drug Administration (FDA) for the treatment of glioblastoma. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

In determining whether a device or service is reasonable and necessary for the treatment of an illness or injury, as required under Medicare, CMS and its Medicare contractors assess relevant health outcomes for the Medicare population. In contrast, the FDA is governed by a different statutory mandate to determine whether a device is safe and effective. Thus, when either CMS decides to open a national coverage determination (NCD) or a Medicare contractor proposes a local coverage determination (LCD), they conduct a separate assessment of a device's eligibility for Medicare coverage, including an evaluation of whether the device is medically appropriate for its intended use by Medicare beneficiaries.

Because this particular device was evaluated at the local level, and not nationally by CMS, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) Medical Director Workgroup researched the clinical literature surrounding this therapy and determined in a LCD that there is insufficient information to establish that Medicare coverage and payment for the NovoTTF therapy device is reasonable and necessary for Medicare beneficiaries. We also understand that the National Cancer Comprehensive Network (NCCN) Level of Consensus and Evidence for the use of alternating electric field therapy (i.e., NovoTTF-100A) for recurrent glioblastoma has recently been downgraded from category 2b to category 3. A treatment with category 3 evidence indicates that, based upon the strength of the evidence, there is major NCCN disagreement regarding whether the intervention is appropriate.

We recognize the importance of making effective treatment for cancer available to patients. However, the DME MACs are prohibited from making payments under the Medicare program for items and services that have not been determined to be reasonable and necessary (the statutory coverage standard), without further medical evidence. If any individual or organization possesses relevant data that have not yet been considered by the DME MACs, they may wish to submit such data to the DME MACs and request a reconsideration of their decision. The process by which a LCD may be reconsidered is found in chapter 13 of the CMS Medicare

Program Integrity Manual on the CMS website at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf>.

Alternatively, any person or organization may request a NCD for NovoTTF Therapy. The process for submitting an NCD request can be found at:

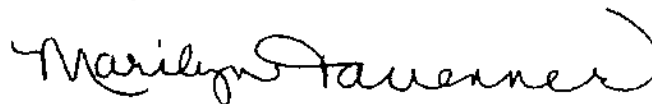
<http://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf>.

In addition, we note that codes were added to the Healthcare Common Procedure Coding System (HCPCS) for the NovoTTF therapy device effective January 1, 2014. Requests for additional edits to the HCPCS can be submitted, and information related to this process is available at

http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Application_Form_and_Instructions.html.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping initial "M".

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

July 31, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RECEIVED
AUG - 6 2014
OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Administrator Tavenner,

We are writing to you regarding recent decisions by the Centers for Medicare and Medicaid Services (CMS) and its local durable medical equipment administrative contractors (DME MACs) with respect to the NovoTTF-100A System, which delivers NovoTTF Therapy for patients seeking second-line treatment of glioblastoma brain tumors. The decisions by Medicare and the DME MACs regarding coverage and coding jeopardize access to NovoTTF Therapy both for Medicare beneficiaries and other patients.

Glioblastoma (GBM) is a malignant brain tumor that affects approximately 10,000 people each year in the United States. The disease is aggressive and after initial treatment of surgery, chemotherapy, and radiation fails, patients have only a few months to live, if not given an effective second line treatment. NovoTTF Therapy is one of only two non-surgical treatments approved by the Food and Drug Administration (FDA) for second-line treatment of the disease. NovoTTF Therapy also allows the patient to receive treatment in their home instead of traveling to the hospital for chemotherapy infusions.

The FDA approved the device through its pre-market approval (PMA) pathway after reviewing data from a randomized controlled trial that tested the safety and efficacy of the device against available chemotherapy treatments.¹ The FDA Center for Devices and Radiological Health ultimately concluded that NovoTTF Therapy produced comparable survival to chemotherapy with fewer side effects and a better quality of life for patients.²

NovoTTF Therapy is consistent with Medicare's mission to provide beneficiaries with access to quality care while promoting innovation that can lower the cost of care by shifting treatments to the home setting and away from the hospital setting.

We ask that CMS, Medicare and the DME MACs, within the scope of existing laws, regulations and rules, reconsider their recent decisions to limit beneficiary access to this therapy. We also ask that CMS provide us with an update after its review of the matter.

¹ Stupp R., ET Wong, et al. *European Journal of Cancer*. 48;14. 2012

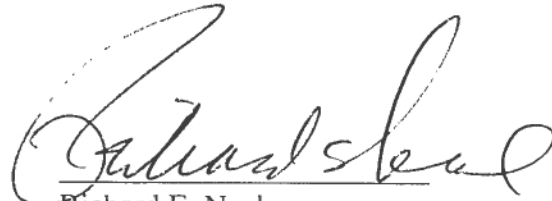
² US FDA Summary of Safety and Effectiveness for the NovoTTF-100A System. April 11, 2011.

Thank you in advance for consideration. If you have any questions, comments or concerns, please feel free to contact Taryn Dorfman in Congressman Stivers' office at (202) 225-2015 or Ann Jablon in Congressman Neal's office at (202) 225-5601.

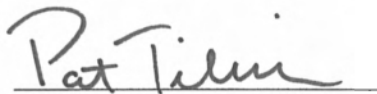
Sincerely,



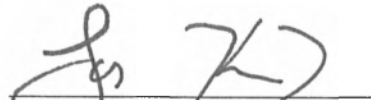
Steve Stivers
Member of Congress



Richard E. Neal
Member of Congress



Patrick J. Tiberi
Member of Congress



Joe Kennedy
Member of Congress



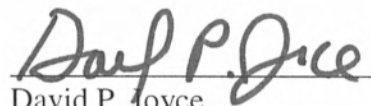
Greg Walden
Member of Congress



Cathy McMorris Rodgers
Member of Congress



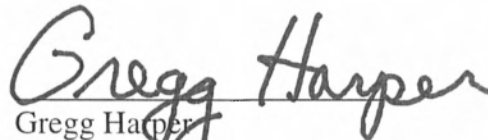
Bob Gibbs
Member of Congress



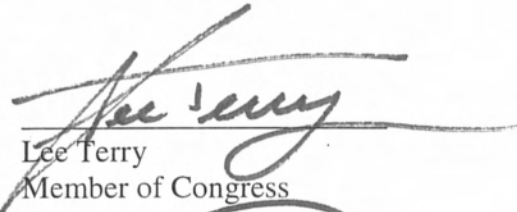
David P. Joyce
Member of Congress



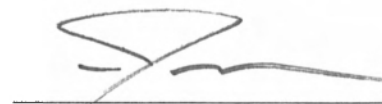
Devin Nunes
Member of Congress



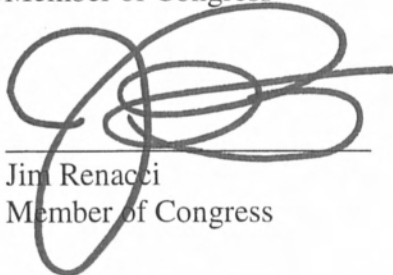
Gregg Harper
Member of Congress



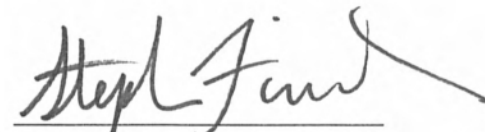
Lee Terry
Member of Congress



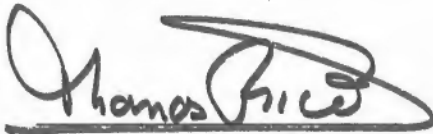
Tom Reed
Member of Congress



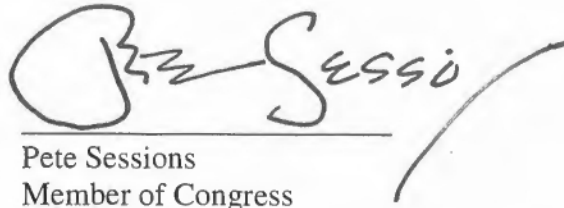
Jim Renacci
Member of Congress



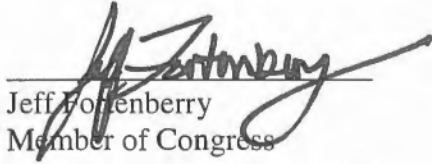
Stephen Fincher
Member of Congress



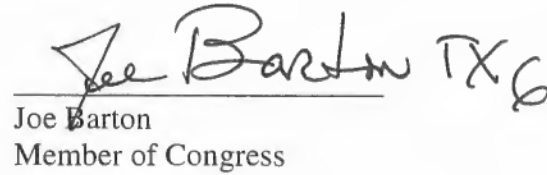
Tom Price, MD
Member of Congress



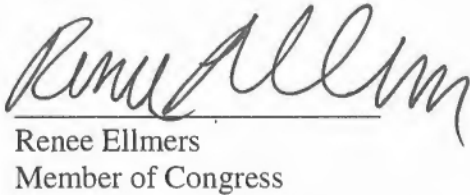
Pete Sessions
Member of Congress



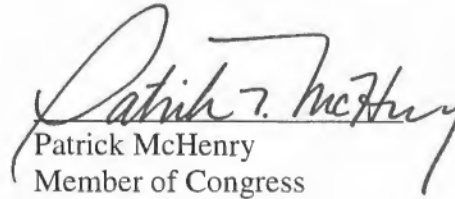
Jeff Fortenberry
Member of Congress



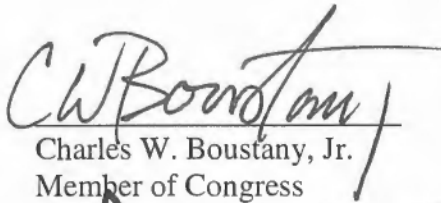
Joe Barton
Member of Congress



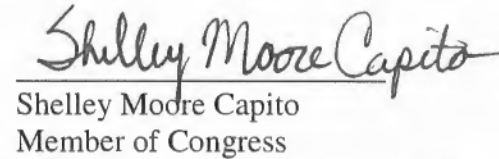
Renee Ellmers
Member of Congress



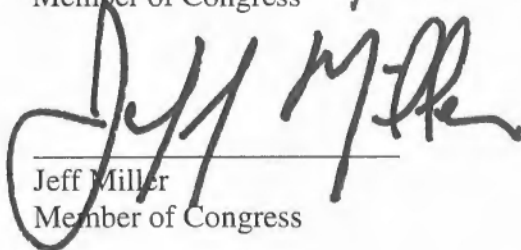
Patrick McHenry
Member of Congress



Charles W. Boustany, Jr.
Member of Congress



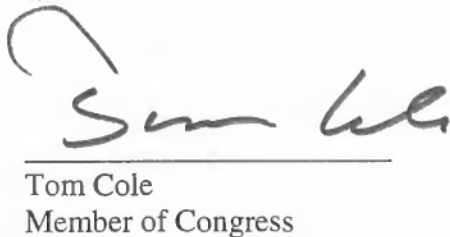
Shelley Moore Capito
Member of Congress



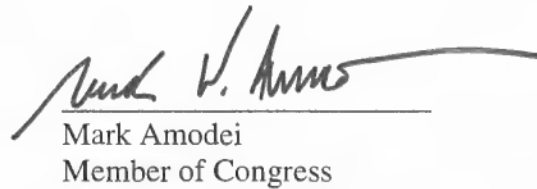
Jeff Miller
Member of Congress



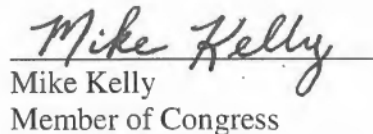
Mac Thornberry
Member of Congress



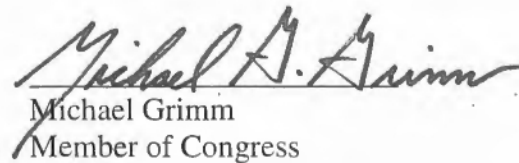
Tom Cole
Member of Congress



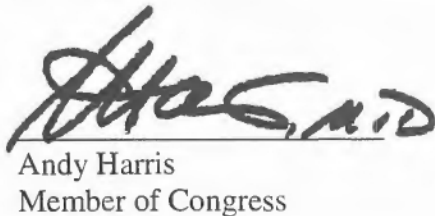
Mark Amodei
Member of Congress



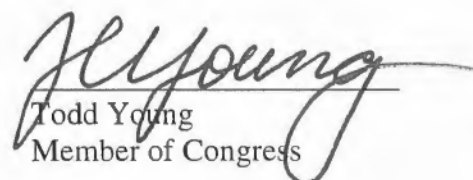
Mike Kelly
Member of Congress



Michael Grimm
Member of Congress



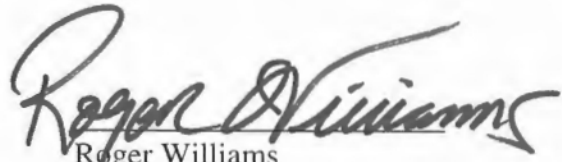
Andy Harris
Member of Congress



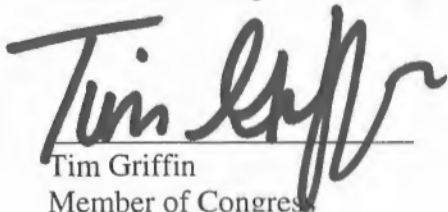
Todd Young
Member of Congress



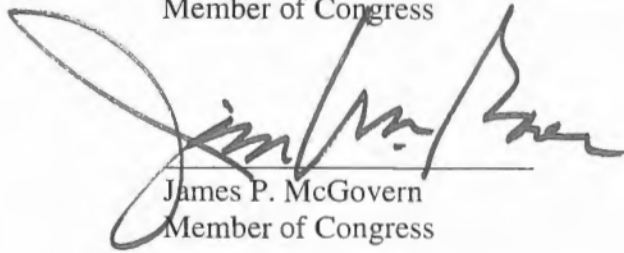
Michael Turner
Member of Congress



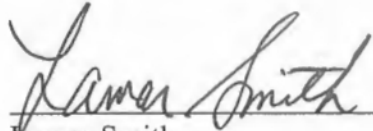
Roger Williams
Member of Congress



Tim Griffin
Member of Congress



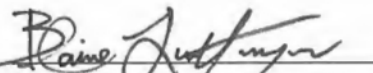
James P. McGovern
Member of Congress



Lamar Smith
Member of Congress



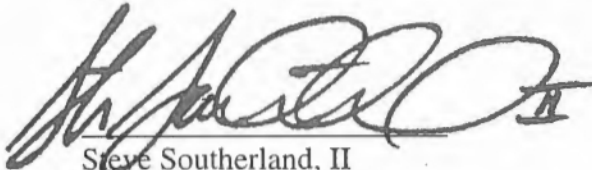
Tim Walberg
Member of Congress



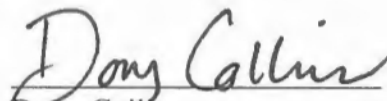
Blaine Luetkemeyer
Member of Congress



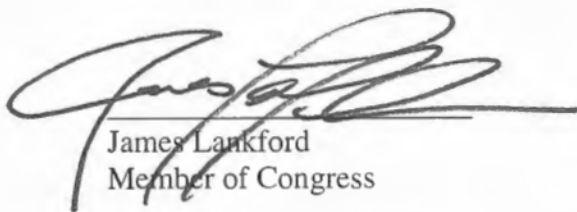
Carol Shea-Porter
Member of Congress



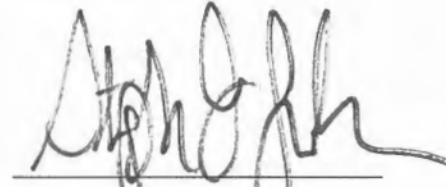
Steve Southerland, II
Member of Congress



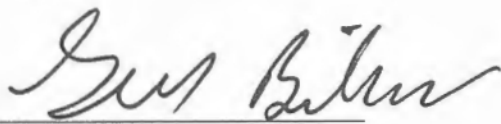
Doug Collins
Member of Congress



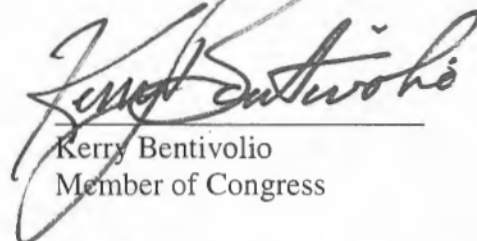
James Lankford
Member of Congress



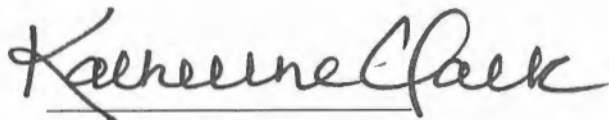
Stephen B. Lynch
Member of Congress



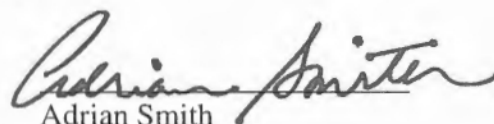
Gus Bilirakis
Member of Congress




Kerry Bentivolio
Member of Congress

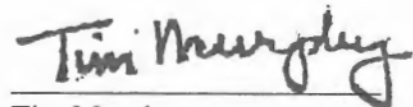


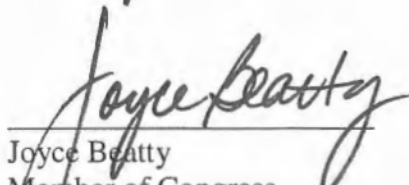
Katherine Clark
Member of Congress

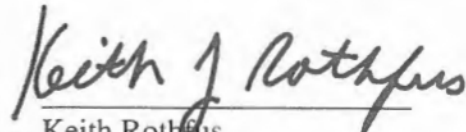



Adrian Smith
Member of Congress

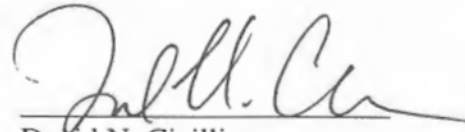

Henry C. "Hank" Johnson
Member of Congress

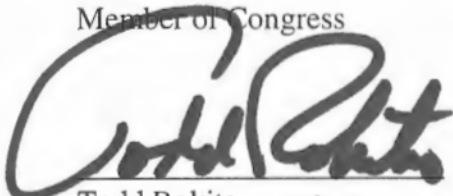

Tim Murphy
Member of Congress



Joyce Beatty
Member of Congress

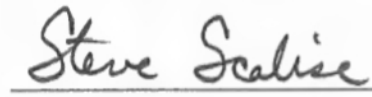

Keith Rothfus
Member of Congress


André Carson
Member of Congress



David N. Cicilline
Member of Congress

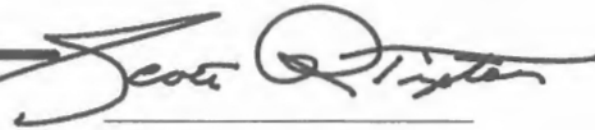

Todd Rokita
Member of Congress

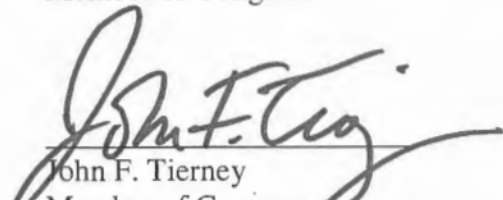

Robert E. Latta
Member of Congress

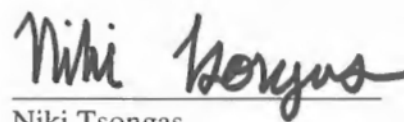

Steve Scalise
Member of Congress

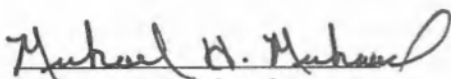

Bill Johnson
Member of Congress


Ann McLane Kuster
Member of Congress


Scott Tipton
Member of Congress


John F. Tierney
Member of Congress


Niki Tsongas
Member of Congress


Michael H. Michaud
Member of Congress



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Shimkus
U.S. House of Representatives
Washington, DC 20515

Dear Representative Shimkus:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Lewis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lewis:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ben Ray Lujan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lujan:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Donald M. Payne, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Payne,:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Patrick Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable James Langevin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Langevin:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Blake Farenthold
U.S. House of Representatives
Washington, DC 20515

Dear Representative Farenthold:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Glenn Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jim Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Cathy McMorris Rodgers
U.S. House of Representatives
Washington, DC 20515

Dear Representative McMorris Rodgers:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jackie Speier
U.S. House of Representatives
Washington, DC 20515

Dear Representative Speier:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Robert Brady
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brady:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tammy Duckworth
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duckworth:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Pompeo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pompeo:

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Lou Barletta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barletta:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bill Posey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Posey:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

The Honorable Erik Paulsen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Paulsen:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Frederica Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Cory Gardner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gardner:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Vern Buchanan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Rogers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Danny Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Greg Walden
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walden:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ileana Ros-Lehtinen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ros-Lehtinen:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jim Matheson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matheson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Pete Sessions
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sessions:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Tierney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tierney:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Keith Ellison
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellison:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Corrine Brown
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brown:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Eleanor Holmes Norton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Norton:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Sheila Jackson Lee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jackson Lee:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Barrow
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barrow:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Richard Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Joe Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Elijah Cummings
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cummings:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Hank Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gwen Moore
U.S. House of Representatives
Washington, DC 20515

Dear Representative Moore:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bill Pascrell, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pascrell,:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Michael Fitzpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fitzpatrick:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bill Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Adam Schiff
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schiff:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Robin Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Conyers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Conyers:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Steve Pearce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pearce:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Doris Matsui
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Madeleine Bordallo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bordallo:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Chris Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Steve Cohen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cohen:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Scott Peters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" being more prominent than the last name "Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable William Lacy Clay
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clay:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Linda T. Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Sanford D. Bishop, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop,:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Lynn Westmoreland
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westmoreland:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Blaine Luetkemeyer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Luetkemeyer:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jim Gerlach
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gerlach:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bruce Braley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Braley:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Lee Terry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Terry:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ken Calvert
U.S. House of Representatives
Washington, DC 20515

Dear Representative Calvert:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Don Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tim Murphy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Marcia L. Fudge
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fudge:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Yvette D. Clarke
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clarke:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Charles B. Rangel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rangel:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Diana DeGette
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeGette:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Adam Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Barbara Lee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lee:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

The Honorable Chaka Fattah
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fattah:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" being more prominent than the last name "Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mac Thornberry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thornberry:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Michael Burgess
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Joe Courtney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Courtney:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

The Honorable Alcee L. Hastings
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hastings:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Shelley Moore Capito
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capito:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Robert Aderholt
U.S. House of Representatives
Washington, DC 20515

Dear Representative Aderholt:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Janice Hahn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hahn:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Karen Bass
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bass:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable David B. McKinley
U.S. House of Representatives
Washington, DC 20515

Dear Representative McKinley:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tom Cotton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cotton:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" being more prominent.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

The Honorable Alan Grayson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grayson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Filemon Vela
U.S. House of Representatives
Washington, DC 20515

Dear Representative Vela:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Suzanne Bonamici
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bonamici:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Eric Swalwell
U.S. House of Representatives
Washington, DC 20515

Dear Representative Swalwell:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Phil Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tom Marino
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marino:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Scott DesJarlais
U.S. House of Representatives
Washington, DC 20515

Dear Representative DesJarlais:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Joyce Beatty
U.S. House of Representatives
Washington, DC 20515

Dear Representative Beatty:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Martha Roby
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roby:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Pete Gallego
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gallego:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable James McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Phil Gingrey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tulsi Gabbard
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gabbard:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Keith Rothfus
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rothfus:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Elizabeth Etsy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Etsy:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Michael Grimm
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grimm:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Julia Brownley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brownley:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Vicky Hartzler
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hartzler:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Daniel Webster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Webster:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Kenny Marchant
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marchant:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Luke Messer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Messer:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ted S. Yoho
U.S. House of Representatives
Washington, DC 20515

Dear Representative Yoho:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable David Valadao
U.S. House of Representatives
Washington, DC 20515

Dear Representative Valadao:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stivers:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Theodore Deutch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Deutch:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Kevin Cramer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cramer:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Morgan M. Griffith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffith:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Markwayne Mullin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Mullin:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Loretta Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Steven L. Fincher
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fincher:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jaime Herrera Beutler
U.S. House of Representatives
Washington, DC 20515

Dear Representative Herrera Beutler:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Sean Duffy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duffy:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Pedro Pierluisi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pierluisi:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Allyson Schwartz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schwartz:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Brad Wenstrup
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wenstrup:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Grace Meng
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meng:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Raul Ruiz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ruiz:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Dave Reichert
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reichert:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bill Cassidy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cassidy:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jerry McNerney
U.S. House of Representatives
Washington, DC 20515

Dear Representative McNerney:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Adam Kinzinger
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kinzinger:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tim Griffin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffin:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jim Costa
U.S. House of Representatives
Washington, DC 20515

Dear Representative Costa:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Chellie Pingree
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pingree:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Steven Horsford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Horsford:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Zoe Lofgren
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lofgren:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ami Bera
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bera:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Michael E. Capuano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capuano:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tim Ryan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ryan:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Derek Kilmer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kilmer:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Andy Barr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barr:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Joseph Crowley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crowley:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Tom Reed
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reed:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mark Takano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Takano:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Trey Gowdy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gowdy:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ed Perlmutter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Perlmutter:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Matt Cartwright
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cartwright:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Alan Nunnelee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunnelee:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Charles W. Boustany
U.S. House of Representatives
Washington, DC 20515

Dear Representative Boustany:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" and last name "Tavenner" clearly legible.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jared Polis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Polis:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Joe Garcia
U.S. House of Representatives
Washington, DC 20515

Dear Representative Garcia:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

The Honorable Susan Brooks
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brooks:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Tony Cardenas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cardenas:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Donna Christensen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Christensen:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Judy Chu
U.S. House of Representatives
Washington, DC 20515

Dear Representative Chu:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Carol Shea-Porter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Shea-Porter:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Juan Vargas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Vargas:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" and last name "Tavenner" clearly legible.

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Grace F. Napolitano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Napolitano:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a white background.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Chris Van Hollen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Van Hollen:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Rick Crawford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crawford:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Daniel Lipinski
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lipinski:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Jeff Denham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Denham:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Dave Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gary C. Peters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gloria Negrete McLeod
U.S. House of Representatives
Washington, DC 20515

Dear Representative McLeod:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Mike M. Honda
U.S. House of Representatives
Washington, DC 20515

Dear Representative Honda:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Richard Nugent
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nugent:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Rodney Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lujan Grisham:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable David Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Todd Rokita
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rokita:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Doyle
U.S. House of Representatives
Washington, DC 20515

Dear Representative Doyle:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Tim Bishop
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" and last name "Tavenner" clearly legible.

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Pete Olson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Olson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bradley S. Schneider
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schneider:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Candice Miller
U.S. House of Representatives
Washington, DC 20515

Dear Representative Miller:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Aaron Schock
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schock:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" and last name "Tavenner" clearly legible.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Colleen Hanabusa
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanabusa:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Cedric Richmond
U.S. House of Representatives
Washington, DC 20515

Dear Representative Richmond:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Rodney Alexander
U.S. House of Representatives
Washington, DC 20515

Dear Representative Alexander:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Suzan DelBene
U.S. House of Representatives
Washington, DC 20515

Dear Representative DelBene:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Dan Kildee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kildee:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Peter King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Mike Coffman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Coffman:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Robert E. Latta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Latta:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Charlie W. Dent
U.S. House of Representatives
Washington, DC 20515

Dear Representative Dent:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bennie G. Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Bob Goodlatte
U.S. House of Representatives
Washington, DC 20515

Dear Representative Goodlatte:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Scott Perry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Perry:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(1) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(1) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Scott R. Tipton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tipton:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable William R. Keating
U.S. House of Representatives
Washington, DC 20515

Dear Representative Keating:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ted Poe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Poe:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Donna F. Edwards
U.S. House of Representatives
Washington, DC 20515

Dear Representative Edwards:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" and last name "Tavenner" clearly legible.

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Andre Carson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carson:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Brian Higgins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Higgins:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gene Green
U.S. House of Representatives
Washington, DC 20515

Dear Representative Green:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kind:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Stephen F. Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

AUG 27 2013

The Honorable Michael T. McCaul
U.S. House of Representatives
Washington, DC 20515

Dear Representative McCaul:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Gus M. Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable John Fleming, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleming,:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable J. Randy Forbes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Forbes:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 ESRD PPS proposed rule was issued on July 1, 2013, with a 60-day comment period that ends on August 30, 2013. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. We appreciate your concerns and we will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule by November 1. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses.

As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system. CMS has been monitoring usage rates on the Medicare ESRD population for ESRD-related drugs, biologicals, and related procedures. CMS has also tracked general health outcomes such as mortality rates, hospitalizations, and emergency department visits, as well as several ESRD-specific health concerns including cardiovascular morbidity, vascular access complications, bone and mineral management, and fluid management. We will continue to monitor these areas when implementing section 632(a) of the American Taxpayer Relief Act of 2012.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



AUG 27 2013

Administrator
Washington, DC 20201

The Honorable Maxine Waters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Waters:

Thank you for your letter regarding the proposed changes to Medicare payments to dialysis facilities for calendar year (CY) 2014 under the end-stage renal disease (ESRD) prospective payment system (PPS). The proposed reduction is required under section 1881(b)(14)(I) of the Social Security Act (the Act), which was added to the Act by section 632(a) of the American Taxpayer Relief Act of 2012. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

Cm

080720134003

DUE-8-21-13

August 1, 2013

Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RECEIVED

AUG 07 2013

OSORA, DIVISION OF
CORRESPONDENCE MANAGEMENT

Dear Administrator Tavenner:

We write to express our concerns about the Centers for Medicare & Medicaid Services (CMS) recently proposed rule on the End-Stage Renal Disease (ESRD) Prospective Payment System.

The new bundled payment system for dialysis has been a remarkable success in payment reform. However, as written, the new proposed rule would have a devastating impact on Medicare beneficiaries who desperately depend on dialysis treatments just to stay alive.

The proposed cut in payments in the pending rule constitute a 12% or a \$30 reduction of what would otherwise be \$246 prospective payment for dialysis. A cut of this magnitude to an industry that, according to the Medicare Payment Advisory Commission, has just 3-4% Medicare margins, could result in closure of dialysis facilities and a reversal of many recent gains that have been made in improving quality of care and mortality for dialysis patients.

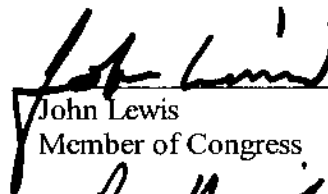
It is our concern that CMS has not considered its full statutory obligations in developing this proposal; it is critical to take analyze the costs of providing dialysis care. As you are aware, CMS has an obligation to link the payment rate to facility costs or other economic and equitable factors. As you move toward finalizing the rule, we hope that the Agency will consider the full impact of the proposed changes in order to ensure that the final payment amount is not less than the cost of providing care.

Again, the new bundled payment system for dialysis shows the great strides we have made, and can make again. We should not let the next rule negatively impact beneficiaries who rely on these critical services. Thank you for your consideration of our comments.

Sincerely,



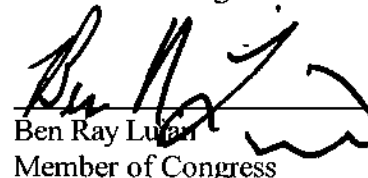
Diane Black
Member of Congress



John Lewis
Member of Congress



John Shimkus
Member of Congress



Ben Ray Lujan
Member of Congress



Tom Price
Member of Congress




Donald Payne
Member of Congress



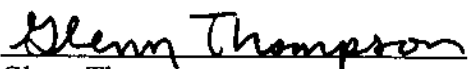
Patrick Tiberi
Member of Congress



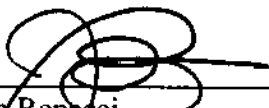
James Langevin
Member of Congress



Blake Farenthold
Member of Congress




Glenn Thompson
Member of Congress



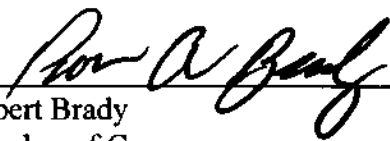
Jim Renacci
Member of Congress



Cathy McMorris Rodgers
Member of Congress



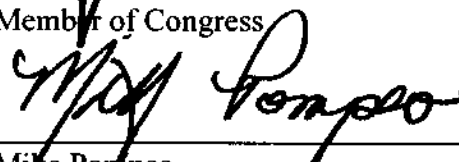
Jackie Speier
Member of Congress



Robert Brady
Member of Congress



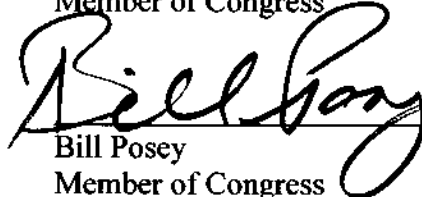
Tammy Duckworth
Member of Congress



Mike Pompeo
Member of Congress



Lou Barletta
Member of Congress



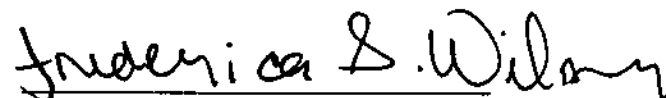
Bill Posey
Member of Congress



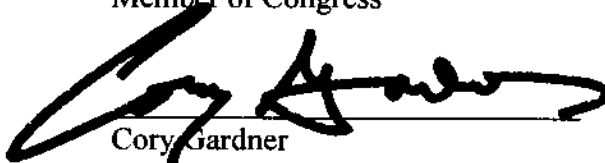
Erik Paulsen
Member of Congress



Leonard Lance
Member of Congress



Frederica Wilson
Member of Congress



Cory Gardner
Member of Congress



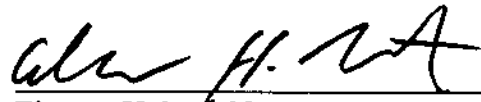
Vern Buchanan
Member of Congress



Corrine Brown
Member of Congress



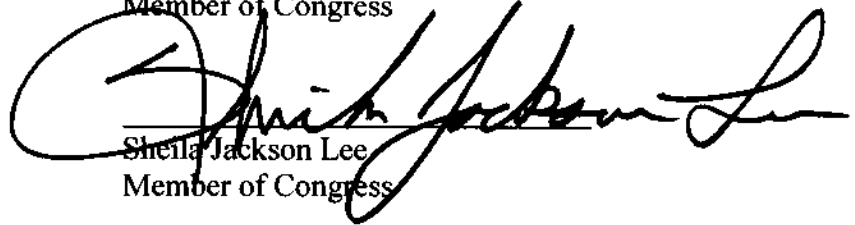
Mike Rogers
Member of Congress



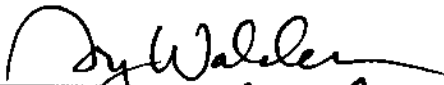
Eleanor Holmes Norton
Member of Congress



Danny Davis
Member of Congress



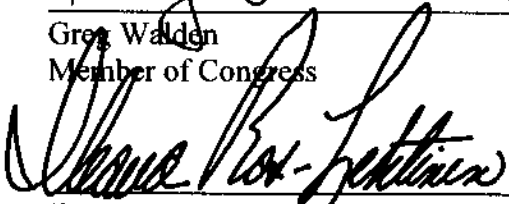
Sheila Jackson Lee
Member of Congress



Greg Walden
Member of Congress



John Barrow
Member of Congress



Ileana Ros-Lehtinen
Member of Congress



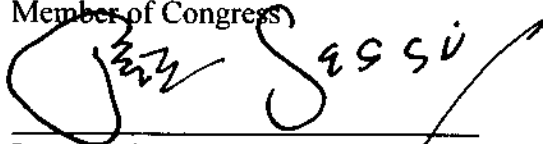
Richard Neal
Member of Congress



Jim Matheson
Member of Congress



Joe Wilson
Member of Congress



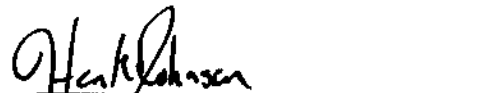
Pete Sessions
Member of Congress



Elijah Cummings
Member of Congress



John Tierney
Member of Congress



Hank Johnson
Member of Congress



Keith Ellison
Member of Congress



Gwen Moore
Member of Congress

Bill Pascrell Jr.

Bill Pascrell
Member of Congress

Michael Fitzpatrick

Michael Fitzpatrick
Member of Congress

Bill Young

Bill Young
Member of Congress

Adam Schiff

Adam Schiff
Member of Congress

Robin Kelly

Robin Kelly
Member of Congress

John Conyers

John Conyers
Member of Congress

Steve Pearce

Steve Pearce
Member of Congress

Doris O. Matsui

Doris Matsui
Member of Congress

Madeleine F. Bordallo

Madeleine Bordallo
Member of Congress

Chris Smith

Chris Smith
Member of Congress

Steve Cohen

Steve Cohen
Member of Congress

Scott Peters

Scott Peters
Member of Congress

Wm. Lacy Clay

Wm. Lacy Clay
Member of Congress

Linda J. Sanchez

Linda Sanchez
Member of Congress

Sanford D. Bishop Jr.

Sanford Bishop
Member of Congress

Lynn Westmoreland

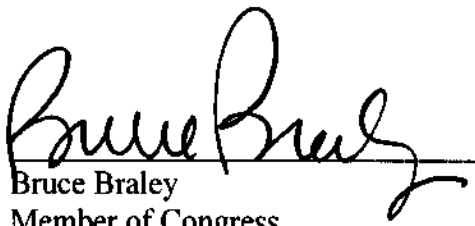
Lynn Westmoreland
Member of Congress


Blaine Luetkemeyer

Blaine Luetkemeyer
Member of Congress


Jim Gerlach


Jim Gerlach
Member of Congress



Bruce Braley
Member of Congress

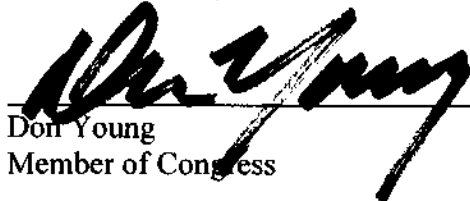

Adam Smith
Member of Congress



Lee Terry
Member of Congress



Barbara Lee
Member of Congress

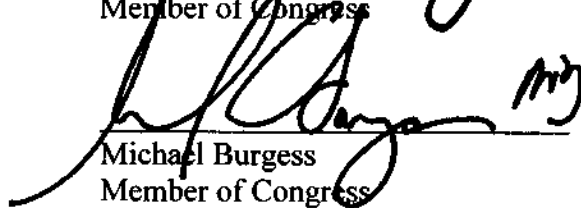

Ken Calvert
Member of Congress

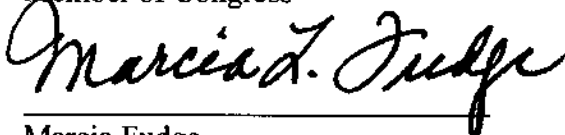

Chaka Fattah
Member of Congress



Don Young
Member of Congress

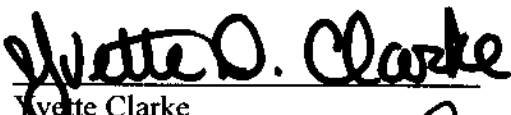

Mac Thornberry
Member of Congress

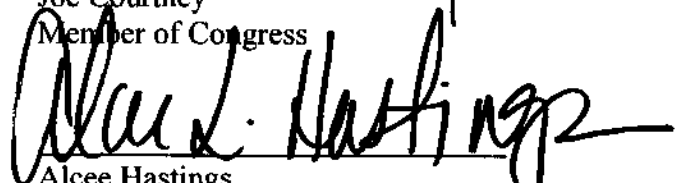

Tim Murphy
Member of Congress

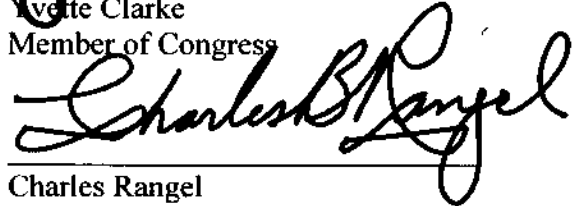

Michael Burgess
Member of Congress



Marcia Fudge
Member of Congress


Joe Courtney
Member of Congress

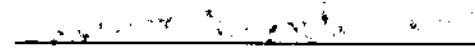

Yvette Clarke
Member of Congress


Alcee Hastings
Member of Congress



Charles Rangel
Member of Congress

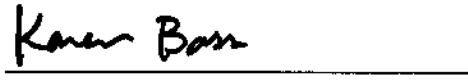

Shelley Moore Capito
Member of Congress



Diana DeGette
Member of Congress

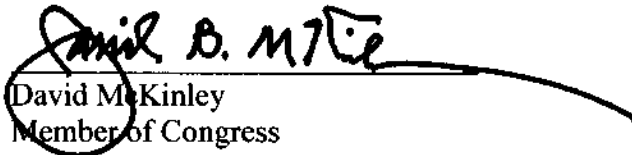

Robert Aderholt
Member of Congress

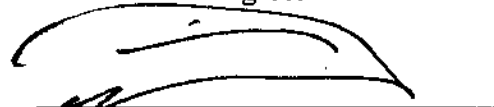

Janice Hahn
Member of Congress



Phil Roe
Member of Congress


Karen Bass
Member of Congress


Tom Marino
Member of Congress


David McKinley
Member of Congress



Scott DesJarlais
Member of Congress



Tom Cotton
Member of Congress

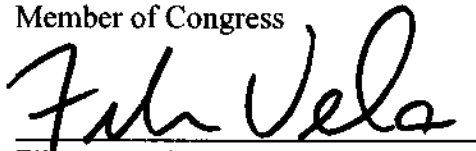

Joyce Beatty
Member of Congress

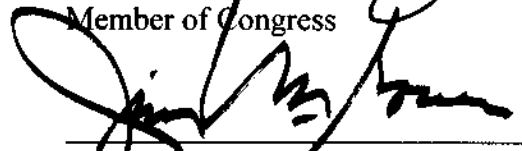

Renee Ellmers
Member of Congress

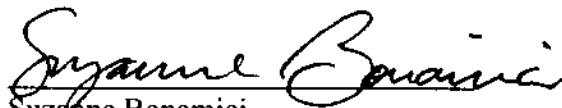

Martha Roby
Member of Congress


Alan Grayson
Member of Congress

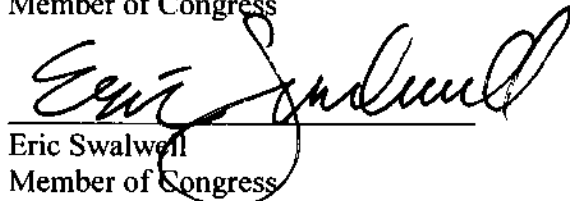

Pete Gallego
Member of Congress


Filemon Vela
Member of Congress



James McGovern
Member of Congress

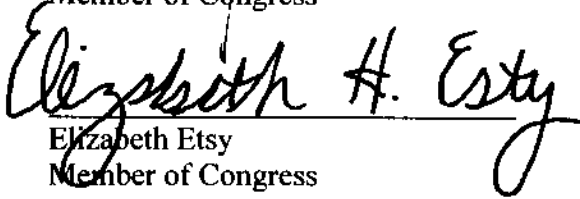

Suzanne Bonamici
Member of Congress

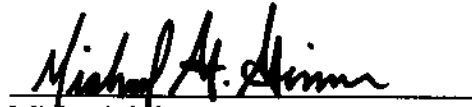

Phil Gingrey
Member of Congress


Eric Swalwell
Member of Congress



Tulsi Gabbard
Member of Congress


Keith Rothfus
Member of Congress



Elizabeth Etsy
Member of Congress

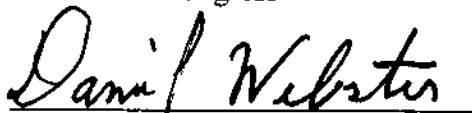

Michael Grimm
Member of Congress

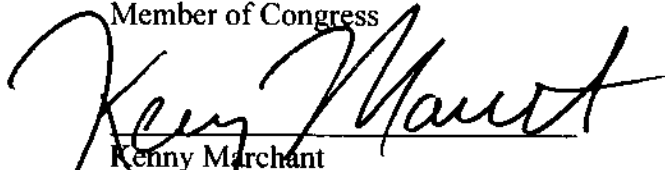

Todd Young
Member of Congress



Julia Brownley
Member of Congress

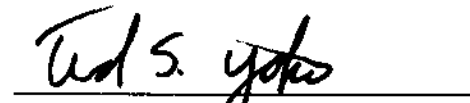

Vicky Hartzler
Member of Congress



Lynn Jenkins
Member of Congress



Daniel Webster
Member of Congress


Kenny Marchant
Member of Congress


Luke Messer
Member of Congress

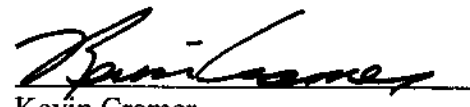

Ted Yoho
Member of Congress

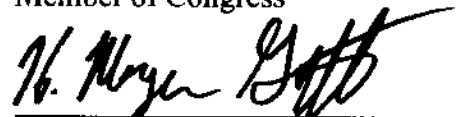

David Valadao
Member of Congress


Devin Nunes
Member of Congress

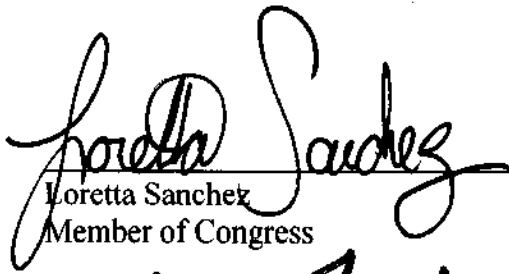

Steve Stivers
Member of Congress

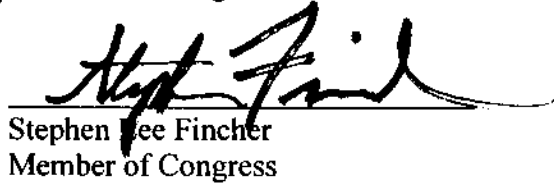

Theodore Deutch
Member of Congress


Kevin Cramer
Member of Congress


Morgan Griffith
Member of Congress

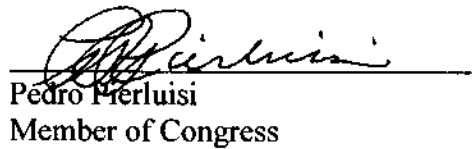

Markwayne Mullin
Member of Congress


Loretta Sanchez
Member of Congress

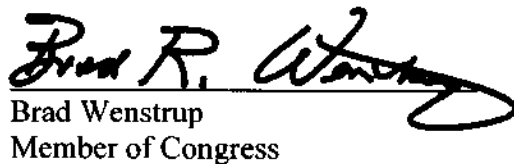

Stephen Lee Fincher
Member of Congress

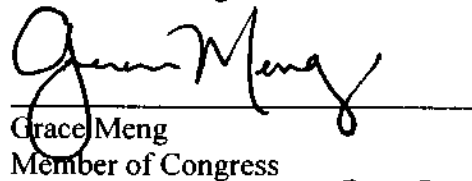

Jaime Herrera Beutler
Member of Congress

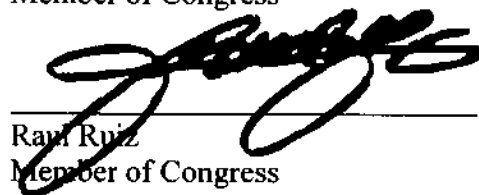

Sean Duffy
Member of Congress

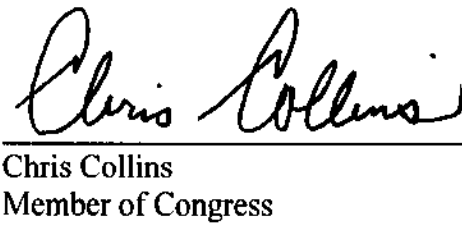

Pedro Pierluisi
Member of Congress


Allyson Schwartz
Member of Congress

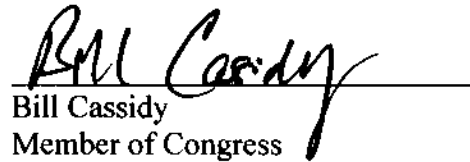

Brad Wenstrup
Member of Congress

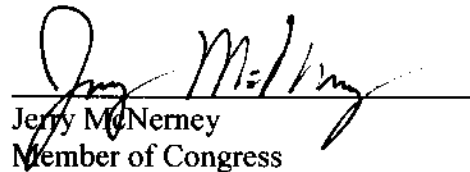

Grace Meng
Member of Congress


Raul Ruiz
Member of Congress


Chris Collins
Member of Congress

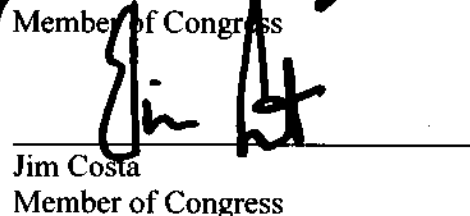

Dave Reichert
Member of Congress

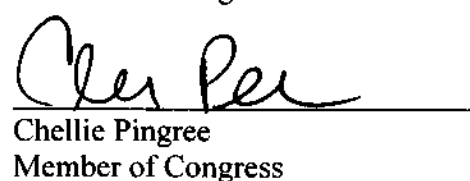

Bill Cassidy
Member of Congress

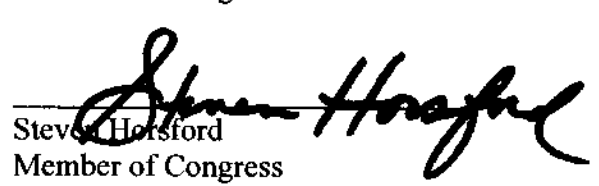

Jerry McNerney
Member of Congress


Adam Kinzinger
Member of Congress


Tim Griffin
Member of Congress


Jim Costa
Member of Congress


Chellie Pingree
Member of Congress

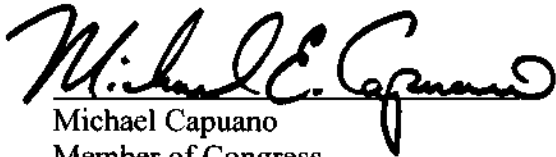

Steven Horsford
Member of Congress



Zoe Lofgren
Member of Congress



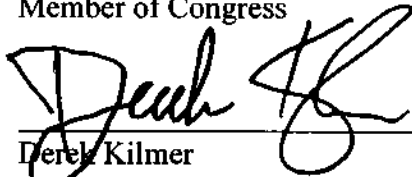
Ami Bera
Member of Congress



Michael Capuano
Member of Congress



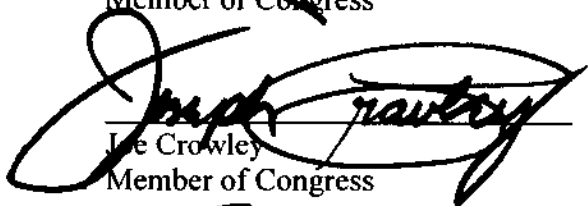
Tim Ryan
Member of Congress



Derek Kilmer
Member of Congress



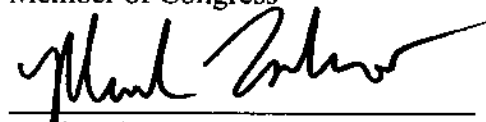
Andy Barr
Member of Congress



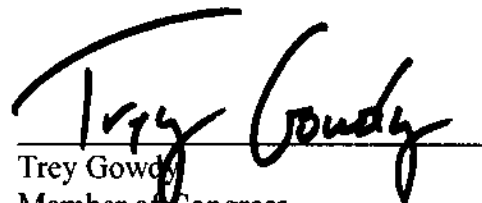
Joe Crowley
Member of Congress



Tom Reed
Member of Congress



Mark Takano
Member of Congress



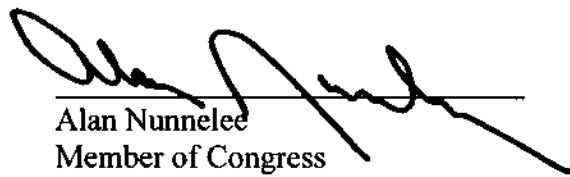
Trey Gowdy
Member of Congress



Ed Perlmutter
Member of Congress



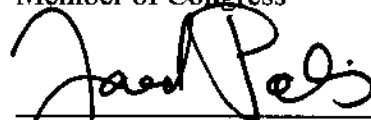
Matt Cartwright
Member of Congress



Alan Nunnelee
Member of Congress



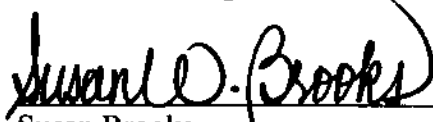
Charles Boustany
Member of Congress



Jared Polis
Member of Congress



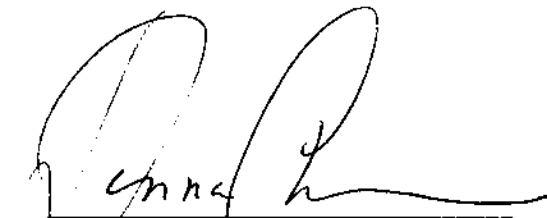
Joe Garcia
Member of Congress




Susan Brooks
Member of Congress

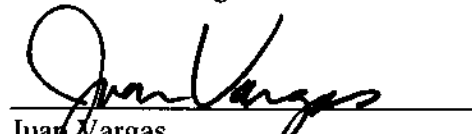



Tony Cardenas
Member of Congress

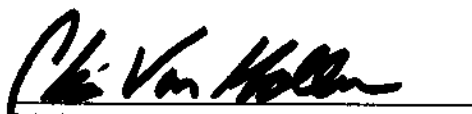

Donna Christensen
Member of Congress



Judy Chu
Member of Congress



Carol Shea-Porter
Member of Congress

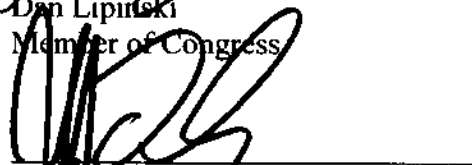

Juan Vargas
Member of Congress



Grace Napolitano
Member of Congress



Chris Van Hollen
Member of Congress



Rick Crawford
Member of Congress


Dan Lipinski
Member of Congress


Jeff Wenham
Member of Congress

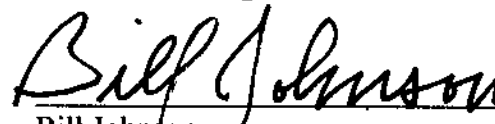

Mike Kelly
Member of Congress

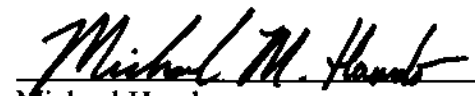

Dave Loebsack
Member of Congress


David Joyce
Member of Congress



Gary Peters
Member of Congress


Gloria Negrete McLeod
Member of Congress


Bill Johnson
Member of Congress


Michael Honda
Member of Congress


Richard Nugent
Member of Congress


Rodney Davis
Member of Congress



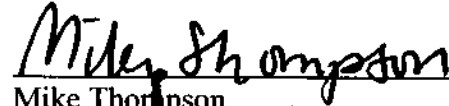
Michelle Lujan Grisham
Member of Congress



Marsha Blackburn
Member of Congress



David Scott
Member of Congress



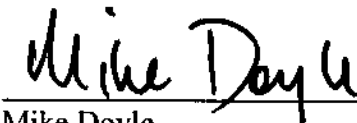
Mike Thompson
Member of Congress



Todd Rokita
Member of Congress



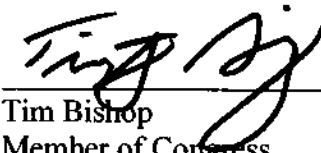
Colleen Hanabusa
Member of Congress



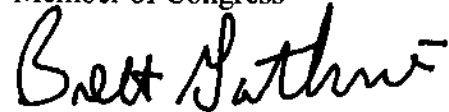
Mike Doyle
Member of Congress



Cedric Richmond
Member of Congress



Tim Bishop
Member of Congress



Brett Guthrie
Member of Congress



Pete Olson
Member of Congress



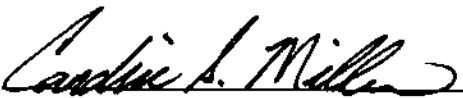
Rodney Alexander
Member of Congress



Brad Schneider
Member of Congress



Suzan DelBene
Member of Congress



Candice Miller
Member of Congress



Dan Kildee
Member of Congress



Aaron Schock
Member of Congress



Peter King
Member of Congress

Mike Coffman

Mike Coffman
Member of Congress

Robert Latta

Robert Latta
Member of Congress

Charlie Dent

Charlie Dent
Member of Congress

Bennie Thompson

Bennie Thompson
Member of Congress

Bob Goodlatte

Bob Goodlatte
Member of Congress

Scott Perry

Scott Perry
Member of Congress

Scott Tipton

Scott Tipton
Member of Congress

William R. Keating

William Keating
Member of Congress

Ted Poe

Ted Poe
Member of Congress

Donna Edwards

Donna Edwards
Member of Congress

Andre Carson

Andre Carson
Member of Congress

Brian Higgins

Brian Higgins
Member of Congress

Gene Green

Gene Green
Member of Congress

Ron Kind

Ron Kind
Member of Congress

Stephen F. Lynch

Stephen F. Lynch
Member of Congress

Michael T. McCaul

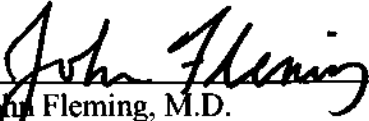
Michael T. McCaul
Member of Congress

Gregg Harper


Gregg Harper
Member of Congress

Gus Bilirakis

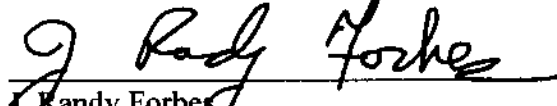
Gus Bilirakis
Member of Congress



John Fleming, M.D.
Member of Congress



Maxine Waters
Member of Congress



J. Kandy Forbes
Member of Congress



AUG 30 2010

Administrator

Washington, DC 20201

The Honorable Tom Cole
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cole:

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In particular, we share your commitment to ensuring that qualified suppliers are selected to participate in the DMEPOS competitive bidding program. Having learned from our initial experience in 2008, we are working aggressively to improve operational processes for the program, address stakeholder concerns, and implement the changes required in the Medicare Improvements for Patients and Providers Act of 2008. To that end, we are dedicating extensive resources within CMS to implement the program in a transparent, orderly, and effective way. In addition, we have held numerous meetings with the Program Advisory and Oversight Committee (PAOC) soliciting their input on all aspects of the competitive bidding program.

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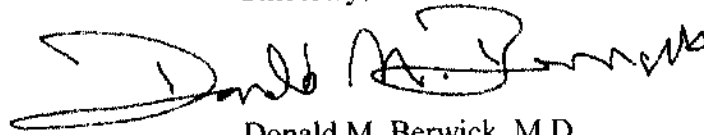
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Page 3 --The Honorable Tom Cole

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Donald M. Berwick, M.D.



Administrator
Washington, DC 20201

AUG 30 2010

The Honorable Todd Russell Platts
U.S. House of Representatives
Washington, DC 20515

Dear Representative Platts:

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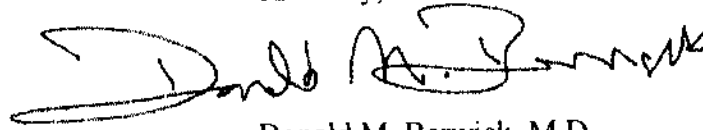
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Donald M. Berwick, M.D.



AUG 30 2010

Administrator
Washington, DC 20201

The Honorable Maurice Hinchey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hinchey:

Thank you for your letter regarding the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and your concerns about the program's ability to meet the medical needs of your constituents. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention and wants to assure you that we share your desire to provide high quality access to care for all Medicare beneficiaries.

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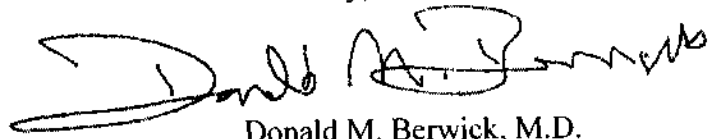
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Donald M. Berwick, M.D.

*Administrator*

Washington, DC 20201

AUG 30 2010

The Honorable Rosa DeLauro
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeLauro:

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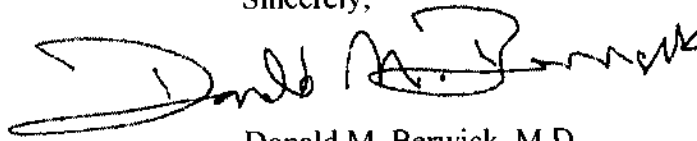
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Administrator
Washington, DC 20201

AUG 30 2010

The Honorable Bruce Braley
U.S. House of Representatives
Washington, DC 20515

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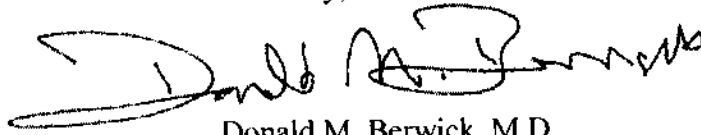
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Donald M. Berwick, M.D.



Administrator
Washington, DC 20201

AUG 30 2010

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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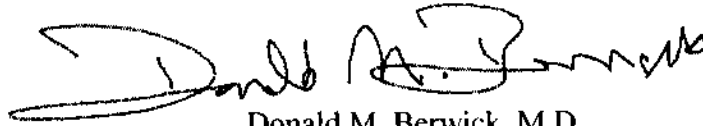
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AUG 30 2010

Administrator
Washington, DC 20201

The Honorable Chris Carney
U.S. House of Representatives
Washington, DC 20515

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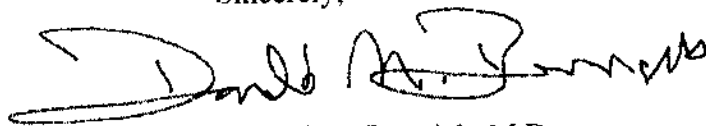
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Donald M. Berwick, M.D.



AUG 30 2010

Administrator
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The Honorable Chris Murphy
U.S. House of Representatives
Washington, DC 20515

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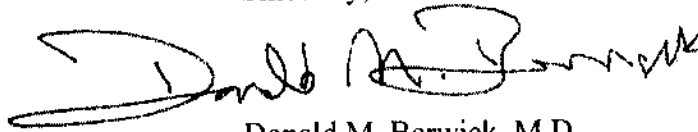
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Donald M. Berwick, M.D.



Administrator
Washington, DC 20201

AUG 30 2010

The Honorable Gus Bilirakis
U.S. House of Representatives
Washington, DC 20515

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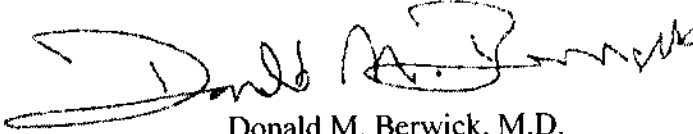
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Washington, DC 20201

AUG 30 2010

The Honorable Mark Steven Kirk
U.S. House of Representatives
Washington, DC 20515

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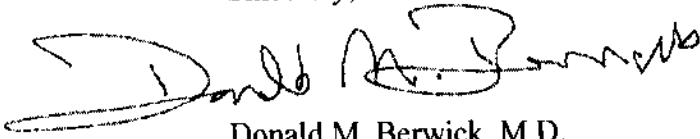
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In addition, the premature release of information may jeopardize the procurement process itself. At the request of the DMEPOS industry, the Request for Bids, which outlined the requirements governing the bid submission and evaluation process, indicated that bidder information could only be disclosed in an anonymous or aggregate format and that proprietary information would be protected from disclosure. Further, standard procurement rules prohibit disclosing the identities of bidders until after contracts are final. Under the DMEPOS competitive bidding program, the contracting process is not complete and contracts are not awarded until CMS signs the contracts, and CMS does not sign the contracts until all of the contract suppliers have signed. Although this is a fairly time-consuming and labor-intensive process, we anticipate that the contracts will be signed by all parties by the end of September. CMS is committed to publicly sharing the list of final contract suppliers at that time. We would be happy to provide a detailed briefing to you and your staff when this announcement is made.

Page 3 –The Honorable Mark Steven Kirk

We appreciate your interest in ensuring that qualified suppliers are participating in the DMEPOS competitive bidding program and look forward to working with you to implement this important program and achieve our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick". The signature is fluid and cursive, with a large initial "D" and "B".

Donald M. Berwick, M.D.



Administrator
Washington, DC 20201

AUG 30 2010

The Honorable Louise Slaughter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Slaughter:

Thank you for your letter regarding the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and your concerns about the program's ability to meet the medical needs of your constituents. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention and wants to assure you that we share your desire to provide high quality access to care for all Medicare beneficiaries.

In particular, we share your commitment to ensuring that qualified suppliers are selected to participate in the DMEPOS competitive bidding program. Having learned from our initial experience in 2008, we are working aggressively to improve operational processes for the program, address stakeholder concerns, and implement the changes required in the Medicare Improvements for Patients and Providers Act of 2008. To that end, we are dedicating extensive resources within CMS to implement the program in a transparent, orderly, and effective way. In addition, we have held numerous meetings with the Program Advisory and Oversight Committee (PAOC) soliciting their input on all aspects of the competitive bidding program.

The current Medicare fee-for-service DMEPOS benefit is plagued by an obsolete pricing methodology, grossly inflated prices, and a well-documented proliferation of fraud. The Department of Health and Human Services' Office of Inspector General, the Government Accountability Office, and other independent analysts have repeatedly highlighted that the prices paid by Medicare for certain DMEPOS items are excessive, sometimes three or four times retail prices and the amounts paid by commercial insurers. The inflated prices, in turn, increase the amount beneficiaries must pay out of pocket for these items.

The DMEPOS competitive bidding program is an essential tool to help CMS pay appropriately for health care—important not only to maintain Medicare beneficiaries' access to high quality medical products, but also to lower costs for beneficiaries and the Medicare program. The program provides proven value to consumers and taxpayers by lowering the cost of medical products, while ensuring consumer access to accredited suppliers that meet stringent quality and financial standards. It also strengthens protections against fraud. By establishing fair, market-based prices for DMEPOS, the competitive bidding program makes such items and supplies a less tempting target for abuse. In addition, contract suppliers will be closely monitored under the program, which reduces the ability of such suppliers to engage in fraudulent activity.

To ensure qualified suppliers are selected to participate in the DMEPOS competitive bidding program, CMS significantly increased our scrutiny of bidders on the front-end, instituting a number of critical improvements to the supplier selection process for the Round One Rebid. For example, we conducted an extremely rigorous and comprehensive verification of bidder compliance with licensure and accreditation requirements early in the bid evaluation process. In addition, we carefully scrutinized supplier capacity statements and expansion plans to verify that suppliers will be ready on day one to begin operating at the level reported in their bids. We included this more intensive review after consultation with members of the PAOC who had raised concerns about bidders entering a new area or product category. We also screened and evaluated all bids to ensure that they represent a rational and feasible payment for furnishing the item (i.e., that they are bona fide). In so doing, we verified that the supplier can furnish an item at the listed bid amount by reviewing additional information beyond that collected in 2008, such as supplier rationales that support documentation like manufacturer's invoices. We believe these process improvements that we have conducted and the intense scrutiny of bidders will result in a fair and effective supplier selection process, addressing the concerns raised following Round One about the need to ensure that suppliers serving Medicare beneficiaries under the program are appropriately qualified.

Another key part of CMS' efforts to implement the competitive bidding program in a transparent, orderly, and effective way is the timing of the announcement of the contract suppliers. While we agree that transparency is important and Congress and the public should have access to the list of final contract suppliers in a timely manner, we do not believe it would be appropriate or in the public interest to release any bidders' names before the contracting process is complete, as there are a number of risks associated with doing so.

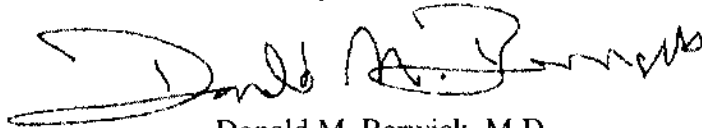
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In addition, the premature release of information may jeopardize the procurement process itself. At the request of the DMEPOS industry, the Request for Bids, which outlined the requirements governing the bid submission and evaluation process, indicated that bidder information could only be disclosed in an anonymous or aggregate format and that proprietary information would be protected from disclosure. Further, standard procurement rules prohibit disclosing the identities of bidders until after contracts are final. Under the DMEPOS competitive bidding program, the contracting process is not complete and contracts are not awarded until CMS signs the contracts, and CMS does not sign the contracts until all of the contract suppliers have signed. Although this is a fairly time-consuming and labor-intensive process, we anticipate that the contracts will be signed by all parties by the end of September. CMS is committed to publicly sharing the list of final contract suppliers at that time. We would be happy to provide a detailed briefing to you and your staff when this announcement is made.

Page 3 –The Honorable Louise Slaughter

We appreciate your interest in ensuring that qualified suppliers are participating in the DMEPOS competitive bidding program and look forward to working with you to implement this important program and achieve our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick". The signature is fluid and cursive, with a large initial "D" and "B".

Donald M. Berwick, M.D.

Congress of the United States
Washington, DC 20515

August 11, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 314
Washington, DC 20201

RECEIVED
AUG 17 2010

OSORA, DIVISION
OF CORRESPONDENCE MANAGEMENT

081720104051
Due - 8/31/10

Dear Administrator Berwick:

We are writing to request that the Centers for Medicare and Medicaid Services (CMS) disclose to us the list of the providers, by product category, whose bids were used to calculate the single payment amounts under the re-bid of Round One of the competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Without knowing the identity as well as the appropriate overall qualifications of these providers, we cannot evaluate the program's impact in terms of quality and access to care for seniors we represent.

As you are aware, during the initial Round One bidding process in 2008, a significant number of providers who signed contracts were later determined to be sufficiently flawed in their qualifications. Among the problems that surfaced were that bidders did not have the financial resources to deliver services to a larger number of patients or they had no experience in the product categories for which they were awarded bids. Additionally, it was discovered that several "winners" did not have the required certification or licensure to provide the devices and services for which they were awarded contracts, or they simply did not have a physical location in the area. It was for these reasons and others that Congress delayed implementation of the program and required a re-bid.

We want to ensure that qualified providers have been chosen to provide these items and services to our constituents. Our district hospitals, physicians and elders who rely on home medical equipment services will be dependent on the winning bid companies for these critical in-home products. The healthcare community will again have very serious problems if it turns out once more that these companies are unable to provide sufficient access to quality items and services or do not have the financial ability to operate under the new contracted rates.

We understand that it is the intent of CMS to release the names of the winning providers in September after it has finalized contracts with these companies. Given the concerns with this process in the past, we seek this information now in order to evaluate the Round One re-bid in an open and transparent manner.

Accordingly, we respectfully request that CMS provide to us a list of the names of the suppliers, product categories and competitive bidding areas for each of the suppliers whose bids were used to determine the payment amounts no later than Friday, August 20, in order to enable us to appropriately assess the program's ability to meet the medical needs of our constituents.

We look forward to receipt of the requested information promptly, and thank you for your cooperation in enabling us to protect the health interests of our seniors.

Sincerely,

Jason Altmire
Jason Altmire

Ralph M. Hall
Ralph Hall

Bob Inglis
Bob Inglis

Michael T. McCaul
Michael T. McCaul

James R. Langevin
James R. Langevin

Bill Posey
Bill Posey

Patrick J. Tiberi
Patrick J. Tiberi

Ron Paul
Ron Paul

Todd W. Akin
Todd W. Akin

Bill Shuster
Bill Shuster

Debbie Wasserman Schultz
Debbie Wasserman
Schultz

Joe Wilson
Joe Wilson

Paul Gingrey
Paul Gingrey

John Barrow
John Barrow

Glenn Thompson
Glenn Thompson

Joe Courtney
Joe Courtney

Michael A. Arcuri
Michael A. Arcuri

Marsha Blackburn
Marsha Blackburn

Paul Tonko
Paul Tonko

Kenny Marchant
Kenny Marchant

Sue Myrick
Sue Myrick

Chris Murphy
Chris Murphy

Suzanne M. Kosmas
Suzanne Kosmas

Ginny Brown-Waite
Ginny Brown-Waite

Charlie Gonzalez
Charlie Gonzalez

Chris Carney
Chris Carney

Ron Klein
Ron Klein

Jean Schmidt
Jean Schmidt

Rodney Alexander
Rodney Alexander

Tom Price
Tom Price

Tim Murphy
Tim Murphy

Phil Hare
Phil Hare

Paul C. Brown
Paul C. Brown

Aaron Schock
Aaron Schock

Peter King
Peter King

Larry Kissell
Larry Kissell

Mike Doyle
Mike Doyle

Brad Ellsworth
Brad Ellsworth

Steve Driehaus
Steve Driehaus

Pete Olson
Pete Olson

John R. Carter
John R. Carter

Kathy Dahlkemper
Kathy Dahlkemper

Steve Cohen
Steve Cohen

John Boehner
John Boehner

Steve King
Steve King

Hank Johnson
Hank Johnson

Bobby Bright
Bobby Bright

Lynn Westmoreland
Lynn Westmoreland

John Hall
John Hall

Betsy Markey
Betsy Markey

*Cathy McMorris
Rodgers*
Cathy McMorris
Rodgers

Sam Graves
Sam Graves

Tim Ryan
Tim Ryan

Randy Neugebauer
Randy Neugebauer

Robert B. Aderholt
Robert Aderholt

Eddie Bernice Johnson
Eddie Bernice Johnson

John Boccieri
John Boccieri

Michael Conaway
Michael Conaway

Joe Donnelly
Joe Donnelly

Robert Latta
Robert Latta

Bob Etheridge
Bob Etheridge

Jim Cooper
Jim Cooper

Niki Tsongas
Niki Tsongas

Grace F. Napolitano
Grace F. Napolitano

Steve Austria
Steve Austria

Chris Lee
Chris Lee

Daniel Lipinski
Daniel Lipinski

Betty Sutton
Betty Sutton

Ileana Ros-Lehtinen

Pete Visclosky

Collin Peterson

Paul Hodes

Heath Shuler

Mary Jo Kilroy

Robert J. Wittman

John Lewis

Zachary Space

Jim McDermott

Charlie Dent

David Wu

Lamar Smith

Peter Roskam

Danny K. Davis

Timothy Bishop

Leonard Boswell

Gus Bilirakis

Henry E. Brown, Jr.

J. Cresham Barrett

Jim Marshall

Kurt Schrader

Alan Grayson

Mike McIntyre

Michael H. Michaud
Michael Michaud

Michael R. 2
Michael R. Turner

Jerry Lewis
Jerry Lewis

Gary L. Ackerman
Gary Ackerman

Tom Graves
Tom Graves

Joe Baca
Joe Baca

Paul E. Kanjorski
Paul E. Kanjorski

Barney Frank
Barney Frank

Ken Calvert
Ken Calvert

Carolyn B. Maloney
Carolyn Maloney

Mac Thornberry
Mac Thornberry

Jerrold Nadler
Jerrold Nadler

Tom Latham
Tom Latham

Carolyn McCarthy
Carolyn McCarthy

Roy Blunt
Roy Blunt

Alcee Hastings
Alcee Hastings

Pete Sessions
Pete Sessions

Charles Rangel
Charles Rangel

Jo Bonner
Jo Bonner

James Oberstar
James Oberstar

John F. Tierney
John Tierney

William Owens
William Owens

Ted Deutch
Ted Deutch

Cliff Stearns
Cliff Stearns

S LaTourette

Steven LaTourette

M Critz

Mark Critz

Chris Smith

Chris Smith

Maurice Hinchey

Maurice Hinchey

Dan Burton

Dan Burton

Jo Ann Emerson

Jo Ann Emerson

Joseph Crowley

Joseph Crowley

Todd Russell Platts

Todd Russell Platts

Bill Young

Bill Young

Steve Israel

Steve Israel

Jerry Costello

Jerry Costello

Tom Cole

Tom Cole

Ed Whitfield

Ed Whitfield

Louise Slaughter

Louise Slaughter

Bruce Braley

Bruce Braley

Joe Sestak

Joe Sestak

Judy Biggert

Judy Biggert

Mark Kirk

Mark Steven Kirk

Rosa DeLauro

Rosa DeLauro

John W. Olver

John Olver



OCT 28 2015

Administrator
Washington, DC 20201

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

Dear Senator Isakson:

Thank you for your letter regarding updates to the ICD-10-PCS to capture procedures such as the insertion of a brain wafer for chemotherapy. As mentioned in your letter, this issue was addressed at the ICD-10 Coordination & Maintenance Committee meeting in March 2014.

The ICD-10 code set has been under a partial code freeze since the last regular code update on October 1, 2011. This partial code freeze limited code updates to new technologies and new diseases until one year after the implementation of ICD-10 to provide stability while the nation planned for this transition. After the error related to the ICD-10 code for the brain wafer chemotherapy was raised at the March 2014 ICD-10 Coordination and Maintenance Committee meeting, ICD-10 implementation was delayed one year from October 1, 2014 until October 1, 2015. Because the brain wafer for chemotherapy is not a new technology, its code cannot be updated until October 1, 2016 when the partial code freeze ends.

In the meantime, hospital coders have been given instruction to use code 3EOQ305, which captures other antineoplastic into cranial cavity and brain, percutaneous approach. This ICD-10-PCS is assigned to the same MS-DRG as was the predecessor ICD-9-CM code; therefore, there is no change in hospital payment. We have reviewed all comments received on code updates addressed during the partial code freeze that are planned for implementation on October 1, 2016. CMS is working on final code updates to share with the public as part of the prospective payment system proposed rule scheduled for publication in April 2016. We will also post complete addenda illustrating those updates in June 2016.

We welcome any additional recommendations for updates to the ICD-10-PCS coding system. Those recommendations should be sent to Megan O'Reilly, Director of the Office of Legislation at megan.oreilly@cms.hhs.gov. These proposals will be addressed at future meetings of the ICD-10 Coordination and Maintenance Committee. Again, thank you for your letter. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT 28 2015

Administrator
Washington, DC 20201

The Honorable David Perdue
United States Senate
Washington, DC 20510

Dear Senator Perdue:

Thank you for your letter regarding updates to the ICD-10-PCS to capture procedures such as the insertion of a brain wafer for chemotherapy. As mentioned in your letter, this issue was addressed at the ICD-10 Coordination & Maintenance Committee meeting in March 2014.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



OCT 28 2015

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding updates to the ICD-10-PCS to capture procedures such as the insertion of a brain wafer for chemotherapy. As mentioned in your letter, this issue was addressed at the ICD-10 Coordination & Maintenance Committee meeting in March 2014.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 314G
Washington, DC 20201

RECEIVED

AUG 17 2015

OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Acting Administrator Slavitt:

It has come to our attention that the transition to the 10th revision of the International Classification of Diseases, Clinical Modification (ICD-10) has incorrectly omitted a procedure code that would impact access to treatment options for brain cancer patients.

Specifically, the ICD-9 Procedure Code ((00.10) *Pharmaceuticals, Implantation of Chemotherapeutic Agent; Brain Wafer Chemotherapy; Interstitial/Intracavitary*) did not transition to the draft ICD-10 code set. This error was communicated to the ICD-10 Code Committee in February of 2014. The Code Committee acknowledged omission of the code and proposed an interim solution which was to assign procedure code 3E0Q305, which describes the introduction of "other antineoplastic into cranial cavity and brain, percutaneous approach." While we appreciate the motivation to address this omission, this solution is ineffective. Unfortunately, this will only add more confusion for providers, as the description is incorrect and does not describe the procedure. In April 2014, stakeholders, including the license holder for the therapy and the Director of the Department of Neurosurgery at Johns Hopkins objected to the proposed solution, as well as the timing.

We write to seek a timely correction to this error prior to implementation of the full code set. CMS should insist that the Code Committee:

- Correct the approach from percutaneous to open;
- Add a qualifier so that the brain wafer chemotherapy treatment remains differentiated from other antineoplastic agents, as it was with the ICD-9 code set; and
- Make the changes effective at the implementation of ICD-10.

CMS has an obligation to ensure that the transition to ICD-10 leaves little disruption to providers and patients. Leaving this error unresolved undermines confidence in CMS' ability to make the transfer and creates potential harm to patients.


081720154023

We look forward to your timely response regarding this issue.

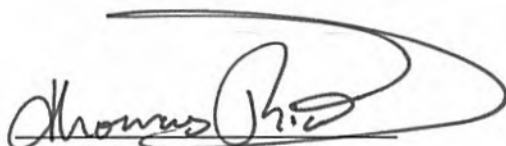
Sincerely,



Johnny Isakson
United States Senator



David Perdue
United States Senator



Tom Price, M.D.
Member of Congress



OCT - 7 2014

Administrator
Washington, DC 20201

The Honorable Erik Paulsen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Paulsen:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I have also provided this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



OCT -7 2014

Administrator
Washington, DC 20201

The Honorable Patrick J. Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

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Sincerely,

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Marilyn Tavenner



OCT -7 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, MD
U.S. House of Representatives
Washington, DC 20515

Dear Dr. Price:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

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Marilyn Tavenner



OCT - 7 2014

Administrator
Washington, DC 20201

The Honorable Marlin A. Stutzman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stutzman:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

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Sincerely,

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Marilyn Tavenner



OCT -7 2014

Administrator
Washington, DC 20201

The Honorable James B. Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

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Marilyn Tavenner



OCT - 7 2014

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" being larger and more prominent than the last name "Tavenner".

Marilyn Tavenner



OCT -7 2014

Administrator
Washington, DC 20201

The Honorable Tim Griffin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffin:

Thank you for your letter regarding the proposed rule addressing the scope of the Medicare coverage exclusion for hearing aids. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The proposed rule regarding hearing aids was published in the *Federal Register* (79 FR 40208) on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We will carefully consider all comments we receive on this issue before making a final determination in the final rule which will be issued by November 1.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I have also provided this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

August 26, 2014

The Honorable Marilyn Tavenner
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Tavenner:

We are writing to express our concerns regarding to Section VII of your Proposed Rule issued on July 2, 2014 entitled, "CY 2015 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Quality Incentive Program, and Changes to the Change in Ownership Policy for DMEPOS." Specifically, the proposal to categorize all middle ear implants, osseointegrated devices, dental anchored bone conduction devices, and other types of these devices that mechanically stimulate the cochlea as hearing aids, and therefore not a covered Medicare benefit, will leave beneficiaries who suffer from profound hearing loss without any treatment options within the Medicare program.

Currently, hearing aids are not considered to be a Medicare benefit. There has been, however, an exception for hearing prostheses, including cochlear implants, osseointegrated devices and brain stem implants, which have been reimbursed and covered by the program. These devices differ from hearing aids in that they do not simply amplify sound in the ear. Rather, these devices produce the perception of sound by electrically or mechanically replacing the function of the middle ear, cochlea or auditory nerve, and are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery.

If this Proposed Rule is finalized, Medicare coverage will be available only for patients with bilateral deafness. There will be no medical treatment covered by Medicare for beneficiaries who are deaf in one ear. The proposal discriminates against patients who are deaf in one ear as a result of tumors or other acquired diseases that destroyed the function of the ear. We firmly believe these patients deserve the same prosthetic treatment options as those with bilateral deafness.

In addition to how this will affect treatments for our constituents, we are deeply concerned as to how this will affect access to modern medical technology. Physicians should be able to recommend products that are in the best interest of patient, yet this technology may no longer be available. Patients with profound hearing loss in one ear should have access to prosthetic technologies that are both surgically-implanted and those that are not surgically-implanted.

Determining what prosthetic technology is a Medicare benefit based on whether it replaces hearing by electrically stimulating the hearing system or through mechanical stimulation and whether it is surgically implanted is without any clinical or legal basis. These are arbitrary lines that will harm patients.

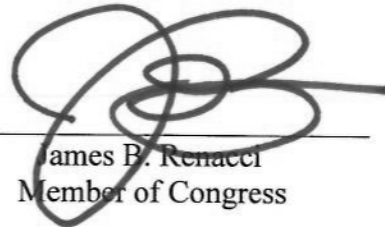
CMS should establish policy that is in the best interest of Medicare beneficiaries consistent with authority granted to the agency by statute. The hearing aid exclusion does not require Medicare to define hearing aids as it is proposing to do. In fact, legislative history informs us the Congress intended the exclusion to capture routine hearing aid use for age related hearing loss - not for patients with unilateral hearing loss due to diseases like acoustic neuromas. Treating age related hearing loss is routine. Treating deafness caused by genetics, infection, trauma or removal of a tumor is not.

As you finalize this Rule, we hope you will consider our comments and ensure that Medicare patients have access to prosthetic technologies that are both surgically-implanted and those that are not surgically implanted in order to replace the function of a hearing system that is otherwise not functioning. We are sending our comments and seeking input only as is permissible under all applicable rules and regulations.

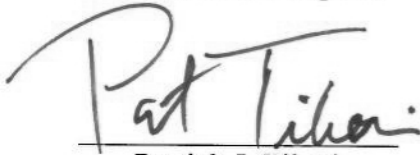
Sincerely,



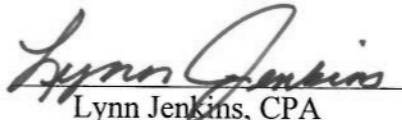
Erik Paulsen
Member of Congress



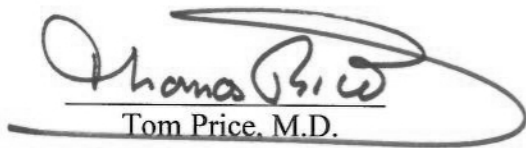
James B. Renacci
Member of Congress




Patrick J. Tiberi
Member of Congress



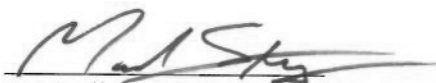
Lynn Jenkins, CPA
Member of Congress



Tom Price, M.D.
Member of Congress



Tim Griffin
Member of Congress



Marlin A. Stutzman
Member of Congress



DEPARTMENT OF HEALTH & HUMAN SERVICES

625831
Centers for Medicare & Medicaid Services

Deputy Administrator
Baltimore, MD 21244-1850

FEB 12 2008

CIS # 625831

The Honorable Sam Johnson
House of Representatives
Washington, DC 20515

Dear Mr. Johnson:

Thank you for your letter regarding the new Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program. Please let me assure you that we are committed to the effective implementation of this important new program, which will result in improved quality and greater value for Medicare and its beneficiaries.

I would first like to address your concerns about the implementation timeline and small suppliers. The Centers for Medicare & Medicaid Services (CMS) worked hard to ensure that suppliers have the information necessary to submit their bids. The proposed regulation was published on May 1, 2006, giving stakeholders an opportunity to submit their comments to help shape the program. Quality standards and the accreditation processes were released in August 2006, and we informed those who would participate in the competitive program to begin preparing by getting accredited.

Preliminary education began months before the final regulation was issued, and the formal education campaign began on April 2, 2007, the day the final regulation was released. For example, prior to opening the supplier bid window on May 15, 2007, we established a dedicated Web site, www.dmecompetitivebid.com, with a comprehensive array of important information for suppliers, including a tool kit, fact sheets, Web casts, and questions and answers. We also held Open Door Forums and sent listserv announcements in order to disseminate key information about the program. After opening the bidding window, we held six bidders' conferences, during which we explained various parts of the bidding process. All of the bidders' conferences were held via teleconference to ensure maximum opportunities for suppliers to participate. We provided extensive education and support to suppliers with the on-line bidding system.

We also continued to issue answers to questions as they arose and posted them on the competitive bid Web site. Finally, we provided a toll-free help desk to aid bidders with all of their questions and concerns. We believe this comprehensive educational campaign provided the information necessary for potential bidders to submit their bids. Despite the comprehensive education campaign, we recognized that suppliers might want additional time to digest the new program and consider their bids. Therefore, in response to supplier requests, we provided several extensions to the bid deadline.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that, in developing procedures relating to bids and the awarding of contracts, the Secretary "take

appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program." In developing and implementing this program, CMS created numerous protections for small suppliers to ensure they have an opportunity to participate. In addition, CMS held a bidders' conference to specifically focus on this aspect of the program.

The small supplier protections include a new definition for small suppliers reflective of the healthcare industry, and a 30 percent target for contract awards to small suppliers. In addition, the final rule allows small suppliers to form networks if they are not able to serve an entire competitive bidding area. In developing this provision, CMS worked with the Antitrust Division of the U.S. Department of Justice to develop regulatory language that specified that any networks must comply with Federal anti-trust laws. In particular, the final rule applies the network provision to small suppliers only, in contrast to the proposed rule, which provided the option to all suppliers. In addition, the rule requires that each member of a network sign a statement certifying that the supplier joined the network because it is unable to furnish all of the items in the product category throughout the entire geographic area of the competitive bidding area.

The final rule ensures that multiple suppliers will be awarded contracts under the program. All contract suppliers will be required to furnish the same products to Medicare beneficiaries under the competitive bidding program as they do their non-Medicare customers. They will also be required to submit quarterly reports demonstrating that items they furnish are the same quality as the items for which the contract supplier submitted a bid and was awarded a contract. We will post on our Web site a list of brands each contract supplier furnishes.

I would also like to assure you that we carefully weighed the concerns you raised on policy issues such as product categories and codes; distinctions between long-term care facilities, home health agencies, and other suppliers; and the use of the median price methodology. These policy issues were all raised during the comment period for the proposed rule for the competitive bidding program. We thoroughly analyzed all of the comments we received on these issues during the rulemaking process.

We believe that that patient access and quality of care are of the utmost importance, and we are committed to monitoring the competitive bidding implementation process carefully to ensure the protection of both. Our plans for assessing patient impact and quality of the competitive bidding program include an ombudsman program that will be established to identify, investigate, and resolve complaints made by or on behalf of beneficiaries, suppliers, or referral agents. The competitive bidding implementation contractor will monitor and evaluate the performance of the ombudsmen in accordance with program-specific goals, objectives, and standards.

In addition, a beneficiary survey will be conducted to gather information regarding the services received from contract suppliers. Claims data will be monitored to identify trends, spikes, or decreases in utilization and changes in utilization patterns within a product category. CMS also has conducted site visits relating to the early operations of the accreditation program. The accreditation process and responses to it provide additional information to evaluate the impact of

Page 3 - The Honorable Sam Johnson

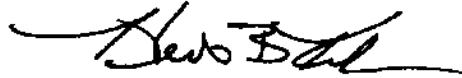
the DMEPOS competitive bidding program and accreditation on the quality of DMEPOS goods and services.

The MMA requires the Secretary of Health and Human Services to submit a report to Congress evaluating the competitive bidding program. The report, due in July 2009, will provide evaluative information from site visits and other sources covering beneficiary satisfaction, quality, access, and program savings.

We expect to conduct a subsequent study which will add evaluative information from the survey data. Data will be collected from both beneficiary surveys and supplier surveys to evaluate changes in beneficiary satisfaction, service, quality, access and cost-sharing as a result of the new competitive bidding program.

I appreciate your interest in this matter, and hope this information is helpful. I also will provide this response to the cosigners of your letter.

Sincerely,



Herb B. Kuhn
Deputy Administrator

625 831

Treat as an original

Congress of the United States
Washington, DC 20515

Cmm
090420084021

Cis # 625831

DUE Date -7-26-07

July 13, 2007

2007 JUL 19 AM 11:23

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C5-11-24
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

We are writing to express our concerns regarding patient access to critical medical technologies and supplies under the new competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) which is required to be implemented by the Centers for Medicare and Medicaid Services (CMS) under section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Access to quality DME and related services can often mean the difference between a patient being able to remain in their own home or being forced into a nursing home or hospital. DME enables providers to give essential care to many of the frailest and sickest Medicare patients, including oxygen therapy for patients with abnormal blood oxygen levels, respiratory-assist devices for patients who are at risk of acute respiratory distress, and enteral nutrition for nutritionally compromised patients.

Although Congress instructed CMS to begin implementing the competitive bidding program in 2007, we strongly believe that due to its direct impact on daily patient care, it must be carefully implemented with significant attention to details, especially the impact on patients. Transitioning to competitive bidding is a major and highly complex undertaking. A large number of issues must be addressed to assure that access and quality of care will not be jeopardized. We strongly urge CMS to take the following steps to address these issues before the bidding process closes and implementation is finalized:

1. **Product Categories and Codes** Product codes used by CMS are too broad and inconsistent to adequately describe products with diverse and broad ranges of quality, functionality, technology, and clinical utility. Beneficiaries may not have access to a full range of products if the accepted bidding amount does not reflect the varying

1. costs of the range of products. Some categories or codes that comprise those categories, such as support services, complex rehabilitation services, enteral nutrition, and negative pressure wound therapy, are so broad or undifferentiated as to raise important quality issues. There is also confusion over how new technologies and products will be categorized once prices are established. We are concerned that patient access to new products may be compromised using these broad and inconsistent codes. **We recommend that CMS accept and give serious consideration to stakeholder input on refinement of proposed product category subdivisions prior to bidding.**
2. **Compressed Implementation Timeline and Small Suppliers.** The Final Rule came out April 10, 2007 and the bidding process closes on July 13, 2007. Winning suppliers will be announced in December 2007 with payments going into effect in the initial 10 competitive bidding areas (CBAs) in April 2008. The Final Rule is highly complex; interested suppliers need a portion of the bidding period to analyze it and gather information to submit informed bids. The 60-day bidding process does not provide sufficient time for suppliers to learn about the important details and obtain answers to key questions relevant to the preparation of their bids, or allow small suppliers to form the provider networks that are needed for them to participate in the program. Currently, CMS is providing more details regarding the program, but this occurring while the clock is ticking on the 60-day window to bid.

Small suppliers that wish to participate in bidding networks must develop new business organizations to maintain Medicare participation, implement untried computer systems, and address a large number of unresolved policy issues. Participating small suppliers would also face steep expenses from the necessary market assessment and compliance procedures that they would have to bear to ensure that their participation does not subject them to antitrust action and other legal risks. Guidance is needed from CMS or the Department of Justice on how suppliers can avoid violating antitrust laws while disclosing information necessary to determine how to form supplier networks. The formation of these networks would require disclosure and agreement between small suppliers on prices and on which competitive opportunities to pursue.

We recommend that CMS realign the bidding timeline to begin the process after all bidder conferences have occurred. We also urge that sufficient time be provided for as many suppliers as possible to begin and conclude the accreditation process.

3. **Distinction Between Long-Term Care Facilities, Home Health Agencies, and DME Companies.** Different skills are required for long-term care facilities, home health agencies, and DME companies. While long-term care facilities provide medical personnel to administer the enteral products, the Part B provider is required to review medical charts of the beneficiaries to determine actual usage for claims submitted. DME companies are not equipped to service the needs of skilled nursing facilities, which may serve 10-20 enteral patients. Suppliers not currently serving the

home care market will have to make significant changes in the way they operate and serve their customers, including carrying products they are currently unfamiliar with and do not have existing relationships with manufacturers or suppliers. Patient care may be at risk as suppliers learn and adapt to new markets.

4. **Median Price Methodology**. Under the median price methodology, half of the "winning" bidders will be paid for DMEPOS at a rate below what they bid. The Final Rule leaves unanswered the question of whether DMEPOS suppliers would be able to withdraw from offering to supply an item if it is below their submitted bid price. We are concerned that 'winning' suppliers may choose not to participate or would be unable to supply quality products and services if they are forced to provide products at a price below their submitted bid price.
5. **Impact on Patients and Medicare Expenditures**. CMS has not yet presented plans to evaluate the impact of competitive bidding on clinical outcomes, beneficiaries, or Medicare expenditures in other care settings. This is concerning because the program will be implemented in a condensed time frame. **We recommend that specific steps be delineated by CMS on how it intends to provide ongoing assessment of the program. This would include clinical outcomes for patients, including those receiving negative pressure wound therapy, support surfaces and blood glucose self-monitoring for patients with diabetes.**

Thank you for your attention to these important issues. We look forward to working with you to address these outstanding concerns before implementation begins.

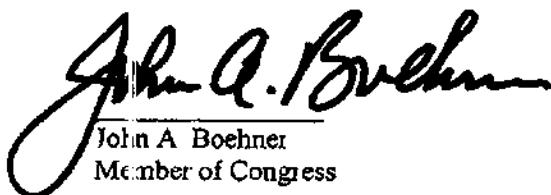
Sincerely,



Sam Johnson
Member of Congress



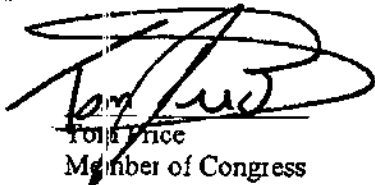
Tom Allen
Member of Congress



John A. Boehner
Member of Congress



Chet Edwards
Member of Congress



Tom Price
Member of Congress



Patrick Kennedy
Member of Congress

Jason Altmire
Jason Altmire
Member of Congress

Sam Farr
Sam Farr
Member of Congress

Paul E. Gillmor
Paul E. Gillmor
Member of Congress

Steve Kagen
Steve Kagen
Member of Congress

Michael H. Michaud
Michael H. Michaud
Member of Congress

John W. Olver
John W. Olver
Member of Congress

Tim Ryan
Tim Ryan
Member of Congress


Pete Sessions
Pete Sessions
Member of Congress

Christopher Shays
Christopher Shays
Member of Congress

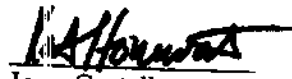
Carol Shea-Porter
Carol Shea-Porter
Member of Congress

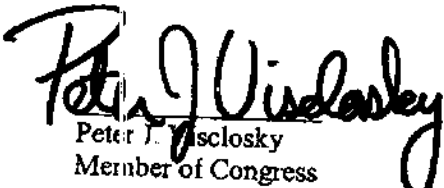
Betty Sutton
Betty Sutton
Member of Congress

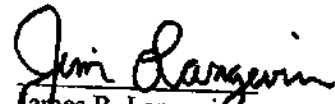
Peter Welch
Peter Welch
Member of Congress



Michael E. Capuano
Member of Congress


John Shimkus
Member of Congress

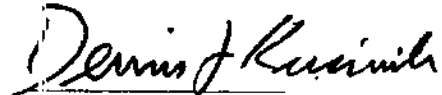

Jerry Costello
Member of Congress


Peter J. Visclosky
Member of Congress


James R. Langevin
Member of Congress


Mike Ross
Member of Congress

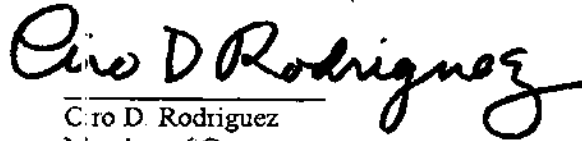

Michael F. Doyle
Member of Congress



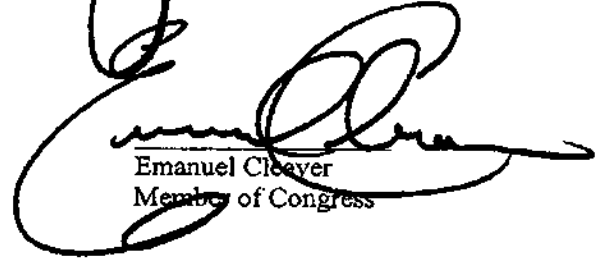
Dennis J. Kucinich
Member of Congress



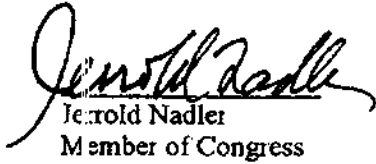
Janice D. Schakowsky
Member of Congress



Ciro D. Rodriguez
Member of Congress



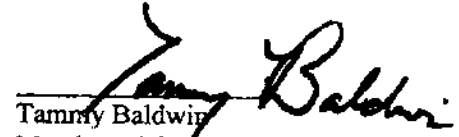
Emanuel Cleaver
Member of Congress



Jerrold Nadler
Member of Congress



Gary L. Ackerman
Member of Congress



Tammy Baldwin
Member of Congress



Rick Boucher
Member of Congress



Danny K. Davis
Member of Congress



William D. Delahunt
Member of Congress



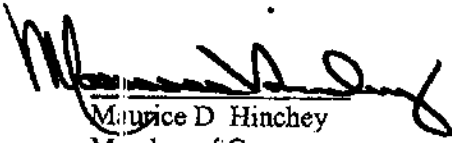
Jo Ann Emerson
Member of Congress



Blaine Frank
Member of Congress



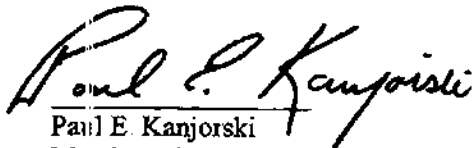
Ralph M. Hall
Member of Congress



Maurice D. Hinchey
Member of Congress



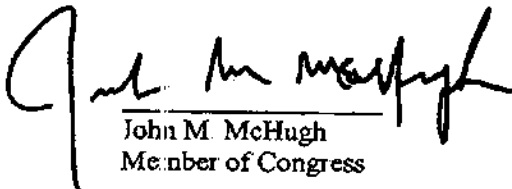
David L. Hobson
Member of Congress



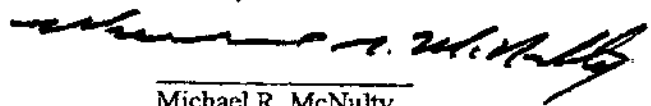
Paul E. Kanjorski
Member of Congress




Steven C. LaTourette
Member of Congress




John M. McHugh
Member of Congress



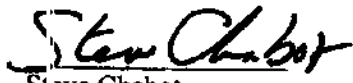
Michael R. McNulty
Member of Congress



Timothy H. Bishop
Member of Congress

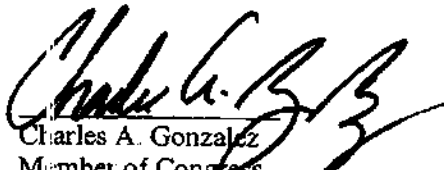

Marsha Blackburn
Member of Congress



Cissy Brown-Waite
Member of Congress

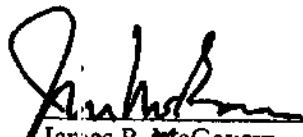

John R. Carter
Member of Congress

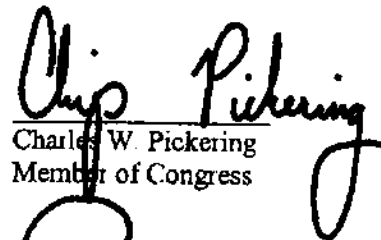

Steve Chabot
Member of Congress



David Davis
Member of Congress



Charles A. Gonzalez
Member of Congress


Brian Higgins
Member of Congress

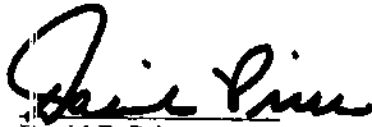

James P. McGovern
Member of Congress


Charles W. Pickering
Member of Congress


Jean Schmidt
Member of Congress


Patrick J. Tiberi
Member of Congress

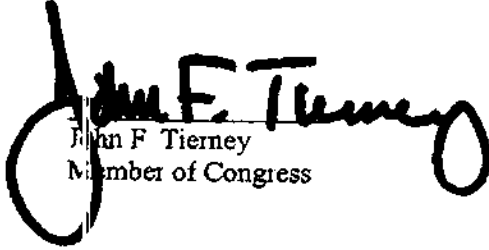

Charles A. Wilson
Member of Congress



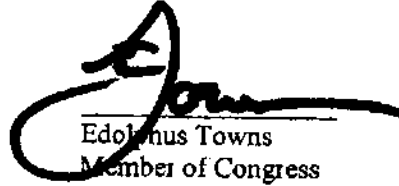
David E. Price
Member of Congress



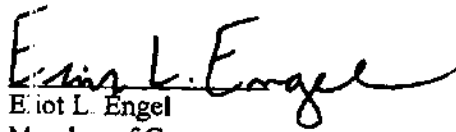
Collin C. Peterson
Member of Congress




John F. Tierney
Member of Congress




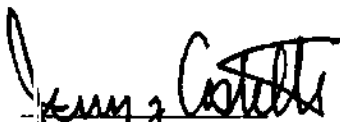
Edouardus Towns
Member of Congress

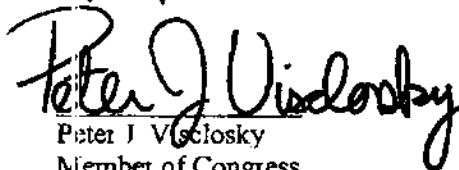


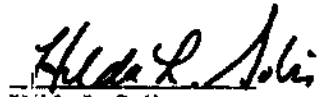
Eliot L. Engel
Member of Congress

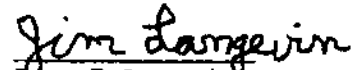

Michael E. Capuano
Member of Congress



John Shimkus
Member of Congress


Harry Costello
Member of Congress



Peter J. Visclosky
Member of Congress



Hilda L. Solis
Member of Congress


James R. Langevin
Member of Congress


Mike Ross
Member of Congress


Michael F. Doyle
Member of Congress


Jerry Lewis
Member of Congress

A handwritten signature in black ink, appearing to read "Geoff Davis". The signature is written in a cursive style with a horizontal line underneath it.

Geoff Davis
Member of Congress



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Bucshon:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide a response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Phil Roe, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Roe:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide a response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Bill Posey
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Posey:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Andy Harris, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Harris:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Charles Boustany, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Boustany:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Lee Terry
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Terry:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Ami Bera, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Bera:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Price:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Michael Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Burgess:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

8CT 14 2014

Administrator
Washington, DC 20201

The Honorable Paul Broun, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Broun:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

PCT 14 2014

Administrator
Washington, DC 20201

The Honorable Patrick Meehan
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Meehan:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Black:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Raul Ruiz, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Ruiz:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Erik Paulsen
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Paulsen:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10- and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Dennis A. Ross
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Ross:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Allyson Schwartz
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Schwartz:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Peter Roskam
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Roskam:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10- and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Anne Wagner
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Wagner:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Brad Wenstrup
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Wenstrup:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Dan Benishck, M.D.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Benishck:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Young:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Blackburn:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Kyrsten Sinema
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Sinema:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10- and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Kind:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Joe Heck, D.O.
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Heck:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Johnson:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 14 2014

Administrator
Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515-2003

Dear Representative Guthrie:

Thank you for your letter regarding our proposal in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule to transition all 10-and 90-day global surgery procedures to 0-day global periods beginning with 10-day global procedures in CY 2017 and following with 90-day global procedures in CY 2018. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner

Congress of the United States
Washington, DC 20515

September 18, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner,

We are writing to express our concern regarding the provision contained in Centers for Medicare and Medicaid Services' (CMS) Physician Fee Schedule (PFS) proposed rule for calendar year (CY) 2015 to convert all 10- and 90-day global procedures to 0-day global procedures beginning in 2017.

We urge CMS not to finalize this proposal in the 2015 Physician Fee Schedule Final Rule and, instead, work with the surgical community and Congress on ways to address the concerns articulated in the proposed rule.

We believe that disrupting global surgical payments will be detrimental to beneficiary care, increase administrative burdens, and hinder the ongoing, systematic efforts to improve and coordinate the delivery of quality health care.

Global payments incentivize providers to coordinate care. We believe that supporting a coordinated, team approach to healthcare is the best way to ensure that patients receive the highest quality, and most efficient care. Without the global payment, we are concerned that surgeons will lose the ability to coordinate postoperative care for critically ill patients. Patients may also be less inclined to attend their follow-up appointments as a result of additional co-pays for each visit.

In addition to compromising individual patient care, eliminating the surgical global payment will limit the collection of patient outcomes information if patients elect to forgo follow-up or seek treatment from other health care providers. Obstructing the use of clinical data registries is a significant setback in the progress that has been made in disease tracking and quality improvement.

Further, current bipartisan, bicameral legislation to repeal and replace the flawed sustainable growth rate formula calls for a "period of stability" in physician pay to allow physicians to transition to alternative payment models. This proposal intends to introduce new complexities into an already flawed system and stymie that progress.

Finally, under CMS' proposal, each pre- and post-operative service will have to be coded and billed separately – increasing the administrative burden to surgeons and the cost to CMS for processing all of these additional claims. The American Medical Association estimates that the

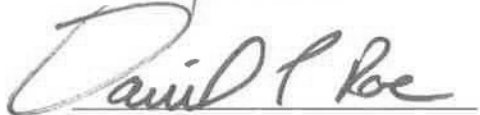
elimination of the global period will result in 63 million additional claims filed to account for post-surgical evaluation and management services. Even if physicians could accommodate this enormous increase in volume, it is not clear that CMS would have the ability to process the information it is requesting.

We urge you not to finalize this proposal in the 2015 PFS Final Rule. Instead, we recommend that CMS work with Congress and the stakeholder community to develop other ways to address the concerns outlined by CMS in the proposed rule while facilitating the development of alternative payment models in the future.

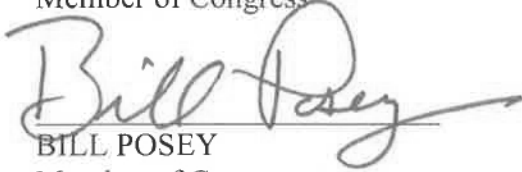
Sincerely,



LARRY BUCSHON, M.D.
Member of Congress



PHIL ROE, M.D.
Member of Congress



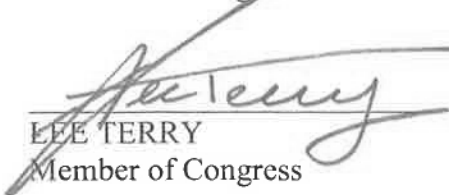
BILL POSEY
Member of Congress



ANDY HARRIS, M.D.
Member of Congress



CHARLES BOUSTANY, M.D.
Member of Congress



LEE TERRY
Member of Congress



AMI BERA, M.D.
Member of Congress



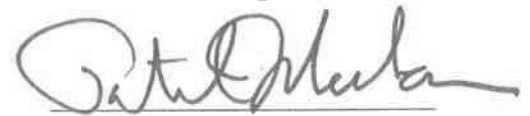
TOM PRICE, M.D.
Member of Congress



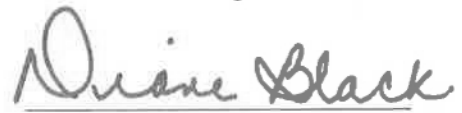
MICHAEL BURGESS, M.D.
Member of Congress



PAUL BROUN, M.D.
Member of Congress



PATRICK MEEHAN
Member of Congress



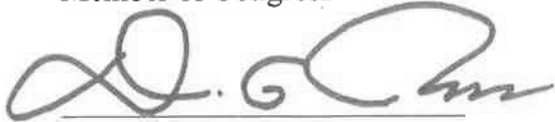
DIANE BLACK
Member of Congress



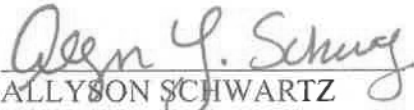
RAUL RUIZ, M.D.
Member of Congress



ERIK PAULSEN
Member of Congress



DENNIS A. ROSS
Member of Congress



ALLYSON SCHWARTZ
Member of Congress



PETER ROSKAM
Member of Congress



ANNE WAGNER
Member of Congress



BRAD WENSTRUP
Member of Congress



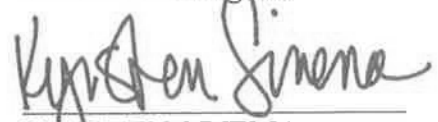
DAN BENISHEK, M.D.
Member of Congress



TODD YOUNG
Member of Congress



MARSHA BLACKBURN
Member of Congress



KYRSTEN SINEMA
Member of Congress



RON KIND
Member of Congress



JOE HECK, D.O.
Member of Congress



BILL JOHNSON
Member of Congress



BRETT GUTHRIE
Member of Congress



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Greg Walden
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walden:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Susan W. Brooks
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brooks:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Chris Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Harold Rogers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Lamar Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Frank A. LoBiondo
U.S. House of Representatives
Washington, DC 20515

Dear Representative LoBiondo:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Ben Ray Luján
U.S. House of Representatives
Washington, DC 20515

Dear Representative Luján:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Eddie Bernice Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Tim Walberg
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walberg:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Brian Higgins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Higgins:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Robert A. Brady
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brady:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Donald M. Payne, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Payne, Jr.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable James R. Langevin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Langevin:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Ryan Zinke
U.S. House of Representatives
Washington, DC 20515

Dear Representative Zinke:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Lou Barletta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barletta:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Glenn G.T. Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Bruce Westerman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westerman:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Michael McCaul
U.S. House of Representatives
Washington, DC 20515

Dear Representative McCaul:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Ann McLane Kuster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kuster:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Ann Kirkpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kirkpatrick:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Garret Graves
U.S. House of Representatives
Washington, DC 20515

Dear Representative Graves:

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lujan Grisham:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Scott R. Tipton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tipton:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Barbara Comstock
U.S. House of Representatives
Washington, DC 20515

Dear Representative Comstock:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Chuck Fleischmann
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleischmann:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Joseph P. Kennedy, III
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kennedy, III:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable William R. Keating
U.S. House of Representatives
Washington, DC 20515

Dear Representative Keating:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Brian Babin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Babin:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Will Hurd
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hurd:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Richard Hanna
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanna:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable John Ratcliffe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ratcliffe:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Frank Guinta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guinta:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Jim Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Steven Plazzo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Plazzo:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Mark Amodei
U.S. House of Representatives
Washington, DC 20515

Dear Representative Amodei:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Jeff Miller
U.S. House of Representatives
Washington, DC 20515

Dear Representative Miller:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Peter T. King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable John Lewis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lewis:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Stephen F. Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Bill Pascrell, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pascrell, Jr.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Tom Marino
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marino:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable David B. McKinley, P.E.
U.S. House of Representatives
Washington, DC 20515

Dear Representative McKinley, P.E.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Scott DesJarlais
U.S. House of Representatives
Washington, DC 20515

Dear Representative DesJarlais:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Ralph Abraham, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Abraham, M.D.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Jackie Walorski
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walorski:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Mike Bishop
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Richard Hudson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hudson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Earl L. Buddy Carter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carter:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Patrick Meehan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meehan:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Bruce Poliquin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Poliquin:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Evan Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Tom Emmer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Emmer:

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I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Paul A. Gosar, D.D.S.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gosar, D.D.S.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Tom MacArthur
U.S. House of Representatives
Washington, DC 20515

Dear Representative MacArthur:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Luke Messer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Messer:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Rick W. Allen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Allen:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Parick J. Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Paul Cook
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cook:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable French Hill
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hill:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Scott Perry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Perry:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Michael E. Capuano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capuano:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Matt Cartwright
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cartwright:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Trent Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Charles W. Boustnay Jr, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Boustnay Jr, M.D.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Andy Barr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barr:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Tony Cárdenas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cárdenas:

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Kathleen M. Rice
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rice:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins, C.P.A.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins, C.P.A.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Dave Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Donald Norcross
U.S. House of Representatives
Washington, DC 20515

Dear Representative Norcross:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Earl Blumenauer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blumenauer:

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Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable James P. McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Dan Benishek, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek, M.D.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon, M.D.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Martha McSally
U.S. House of Representatives
Washington, DC 20515

Dear Representative McSally:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



DC7 - 7 2015

Administrator
Washington, DC 20201

The Honorable Steve Womack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Womack:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable John Katko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Katko:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Billy Long
U.S. House of Representatives
Washington, DC 20515

Dear Representative Long:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Rick Crawford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crawford:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Katherine M. Clark
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clark:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Michael M. Honda
U.S. House of Representatives
Washington, DC 20515

Dear Representative Honda:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Niki Tsongas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tsongas:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Dave Trott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Trott:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Rodney Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable John R. Carter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carter:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Gus M. Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Pete Olson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Olson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Peter Defazio
U.S. House of Representatives
Washington, DC 20515

Dear Representative Defazio:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable J. Randy Forbes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Forbes:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Ander Crenshaw
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crenshaw:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - ? 2015

Administrator
Washington, DC 20201

The Honorable Chellie Pingree
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pingree:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Lynn Westmoreland
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westmoreland:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable John Duncan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duncan:

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Mac Thornberry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thornberry:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Joe Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Pete Sessions
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sessions:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Betty McCollum
U.S. House of Representatives
Washington, DC 20515

Dear Representative McCollum:

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Rubén Hinojosa
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hinojosa:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Peter Welch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Welch:

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Doris Matsui
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Linda T. Sánchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sánchez:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Walter B. Jones, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jones, Jr.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Albio Sires
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sires:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Yvette D. Clarke
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clarke:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Alcee L. Hastings
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hastings:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Brendan F. Boyle
U.S. House of Representatives
Washington, DC 20515

Dear Representative Boyle:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Kathy Castor
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castor:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Robert Dold
U.S. House of Representatives
Washington, DC 20515

Dear Representative Dold:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Richard E. Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Phil Roe, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe, M.D.:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Suzanne Bonamici
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bonamici:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable David G. Valadao
U.S. House of Representatives
Washington, DC 20515

Dear Representative Valadao:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Sam Farr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Farr:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Bill Huizenga
U.S. House of Representatives
Washington, DC 20515

Dear Representative Huizenga:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The home health proposed rule was issued on July 6, 2015, with a 60-day comment period that closed on September 4, 2015. We appreciate your concerns and will consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its ultimate payment rate determinations in the final regulation, along with a summary of the comments received and our responses. The final regulation is expected to be issued by November 1, 2015.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Seth Moulton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Moulton:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Sam Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

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Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Mike Simpson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Simpson:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Mike Fitzpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fitzpatrick:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Austin Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT -7 2015

Administrator
Washington, DC 20201

The Honorable Kristi Noem
U.S. House of Representatives
Washington, DC 20515

Dear Representative Noem:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Cathey McMorris Rodgers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rodgers:

Thank you for your letter regarding your concerns with the proposed Medicare home health payment rate reductions in the calendar year 2016 Home Health Prospective Payment System proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

September 18, 2015

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Acting Administrator Slavitt:

We are writing today to express our concern with Medicare home health funding cuts set forth in the Home Health Prospective Payment System (HHPPS) proposed rule for 2016. Home healthcare is a vital service that allows millions of the most vulnerable senior citizens and disabled individuals to receive the treatment they need in the cost-effective environment they most prefer – their home. As a result, we request a careful reconsideration of two of the draft policy changes in light of their anticipated impact on homebound Medicare beneficiaries and the home health delivery system upon which they depend.

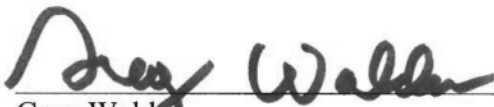
First, we are concerned with the draft HHPPS rule's proposal to cut home health payment rates by an additional 1.72 percent in 2016 and again in 2017. This proposed "case mix" reduction is of concern because it appears to be based on a 2000-2010 case mix weight change analysis rather than changes in the condition of beneficiaries during the 2012 to 2014 period that Medicare proposes to address.

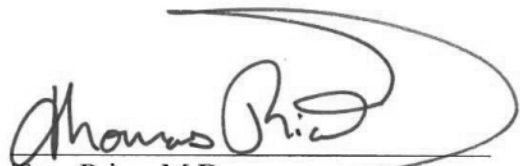
Second, the draft rule proposes a Home Health Value-Based Purchasing (HHVBP) program that would impose an incentive/penalty range of as much as 5 to 8 percent over a 5-year period. We are very concerned with the aggressive nature in which the Secretary intends to ramp up HHVBP. Implementing a VBP program with a 5 percent withhold that increases to 8 percent just three years later is too much too fast. We are also concerned that the Secretary is proposing 25 measures for use in the HHVBP— far too many for providers to focus on.

In closing, we wish to express our concern that, in its current form, the draft rule may drive Medicare reimbursement to unsustainable levels for thousands of small, rural and other home health providers across the country, impacting the care upon which many of the most vulnerable Medicare beneficiaries, as well as their communities, depend. As a result, we request that the Agency reconsider its proposed case mix cut until it evaluates the specific causes of case mix weight changes from 2012 to 2014 and consider a more reasonable implementation schedule for the proposed withhold amount in the HHVBP program.

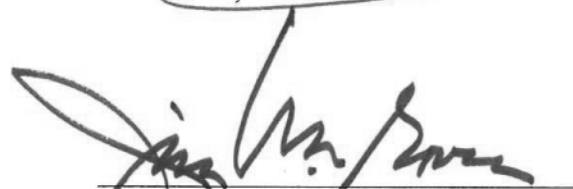
We thank you for your attention to this critical matter.


Sincerely,


Greg Walden

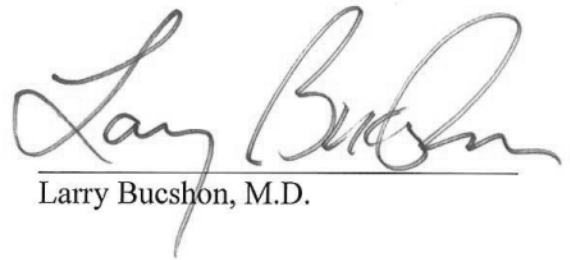

Tom Price, M.D.


Earl Blumenauer


James P. McGovern



Dan Benishek, M.D.



Larry Bucshon, M.D.



Todd Young



Devin Nunes



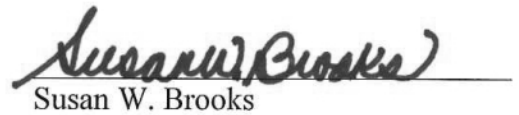
Martha McSally



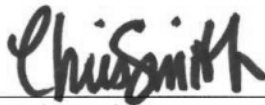
Steve Womack



John Katko



Susan W. Brooks



Chris Smith



Harold Rogers



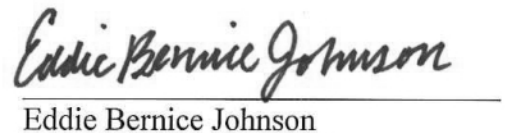
Lamar Smith



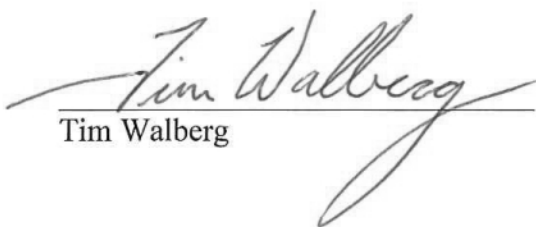
Frank A. LoBiondo




Ben Ray Luján



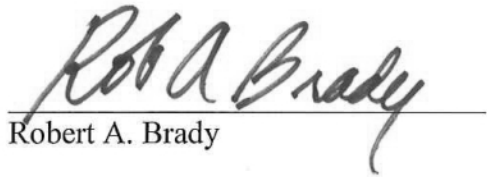
Eddie Bernice Johnson

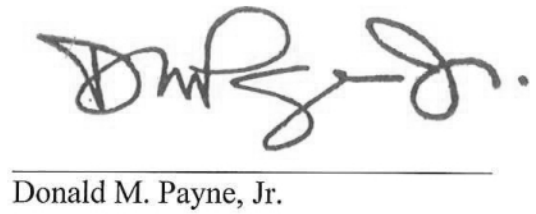


Tim Walberg

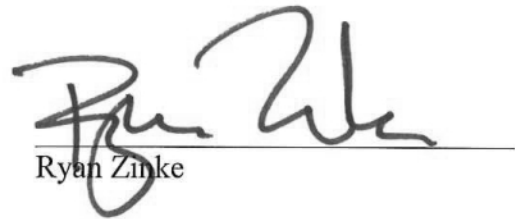


Brian Higgins

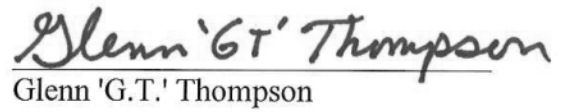

Robert A. Brady


Donald M. Payne, Jr.

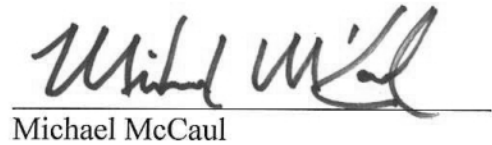

James R. Langevin


Ryan Zinke

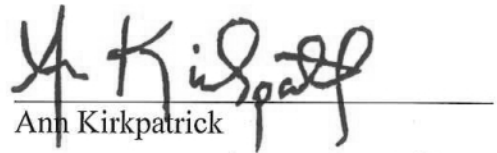

Lou Barletta

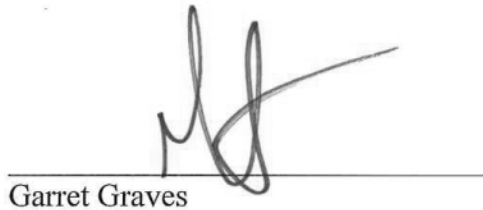

Glenn 'G.T.' Thompson

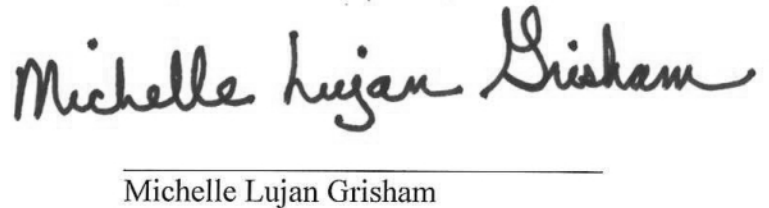

Bruce Westerman

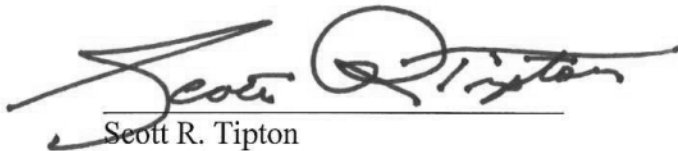

Michael McCaul

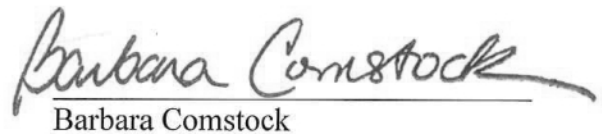

Ann McLane Kuster


Ann Kirkpatrick

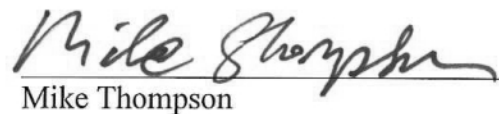

Garret Graves



Michelle Lujan Grisham


Scott R. Tipton


Barbara Comstock


Chuck Fleischmann


Mike Thompson


Joseph P. Kennedy, III


Gregg Harper

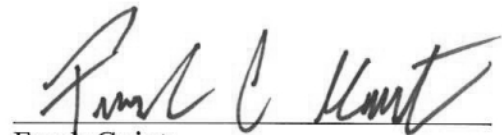

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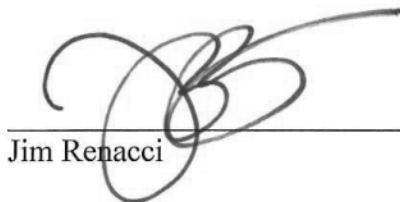

Brian Babin


Will Hurd

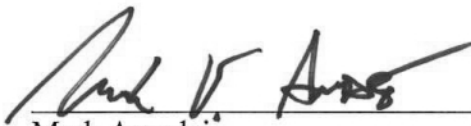

Richard Hanna


John Ratchiffe


Frank Guinta

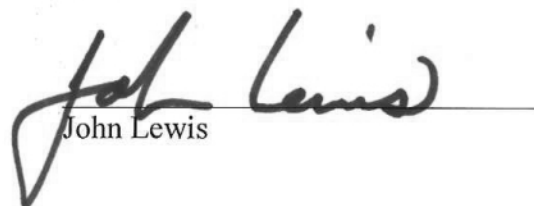

Jim Renacci


Steven Palazzo


Mark Amodei


Jeff Miller


Peter T. King


John Lewis


Stephen F. Lynch


Bill Pascrell, Jr.

Tom Marino

Tom Marino

David B. McKinley

David B. McKinley, P.E.

Scott DesJarlais

Scott DesJarlais

Ralph Abraham

Ralph Abraham, M.D.

Jackie Walorski

Jackie Walorski

Michael D. Bishop

Mike Bishop

Richard Hudson

Richard Hudson

Earl L. "Buddy" Carter

Earl L. "Buddy" Carter

Patrick Meehan

Patrick Meehan

Bruce Poliquin

Bruce Poliquin

Evan H. Jenkins

Evan Jenkins

Tom Emmer

Tom Emmer

Paul A. Gosar, D.D.S.

Paul A. Gosar, D.D.S.

Tom MacArthur

Tom MacArthur

Luke Messer

Luke Messer

Rick W. Allen

Rick W. Allen

David P. Joyce

David P. Joyce

Diane Black

Diane Black

Patrick J. Tiberi

Patrick J. Tiberi

Scott Perry

Scott Perry

Paul Cook

Paul Cook

French Hill

French Hill

Michael E. Capuano

Michael E. Capuano

Matt Cartwright

Matt Cartwright

Trent Kelly

Trent Kelly

Charles W. Boustany Jr., M.D.

Charles W. Boustany Jr., M.D.

Andy Barr

Andy Barr

Kathleen M. Rice

Kathleen M. Rice

Tony Cárdenas

Tony Cárdenas

Mike Kelly

Mike Kelly

Lynn Jenkins, C.P.A.

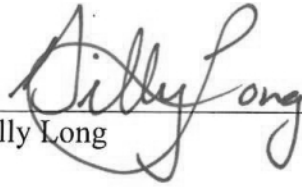
Lynn Jenkins, C.P.A.

Dave Loebsack

Dave Loebsack



Donald Norcross



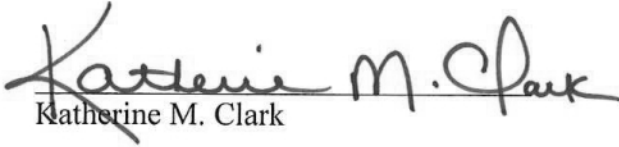
Billy Long



Bill Johnson



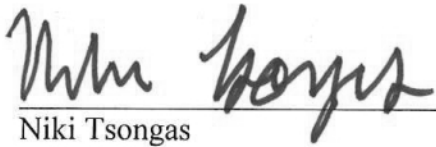
Rick Crawford



Katherine M. Clark



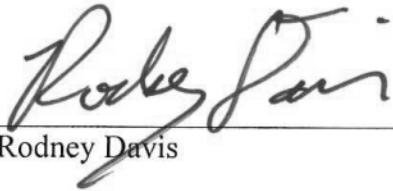
Michael M. Honda



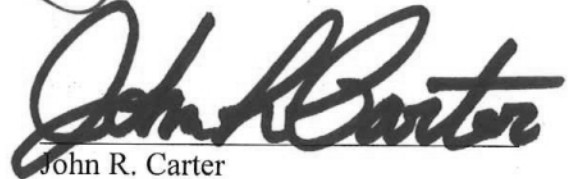
Niki Tsongas



Dave Trott



Rodney Davis



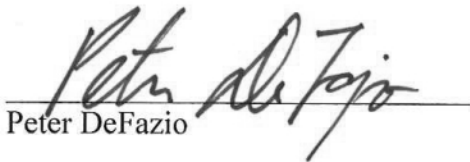
John R. Carter



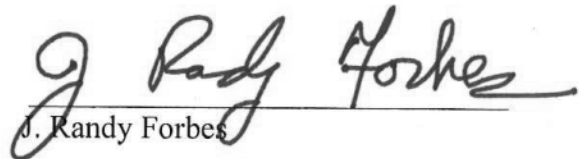
Gus M. Bilirakis



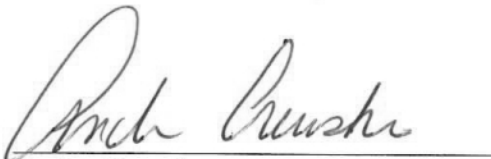
Pete Olson



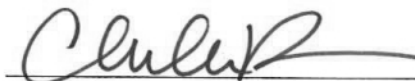
Peter DeFazio



J. Randy Forbes

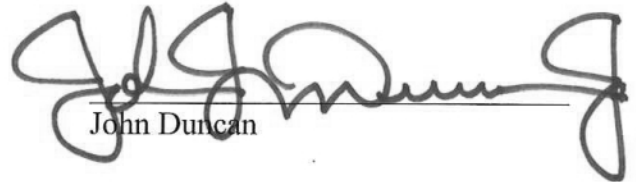


Ander Crenshaw



Chellie Pingree


Lynn Westmoreland


John Duncan


Mac Thornberry

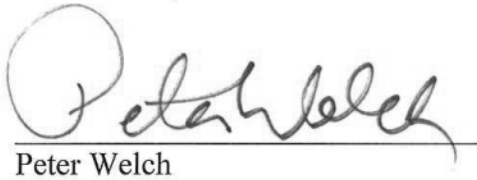

Joe Wilson


Pete Sessions


Betty McCollum

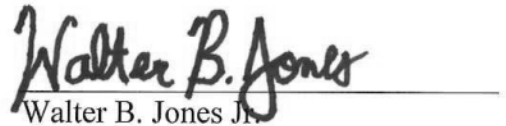

Rubén Hinojosa


Marsha Blackburn

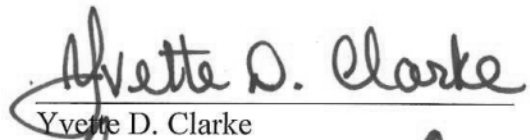

Peter Welch

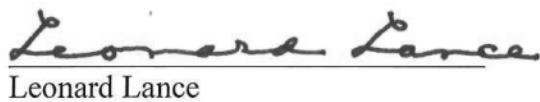

Doris Matsui

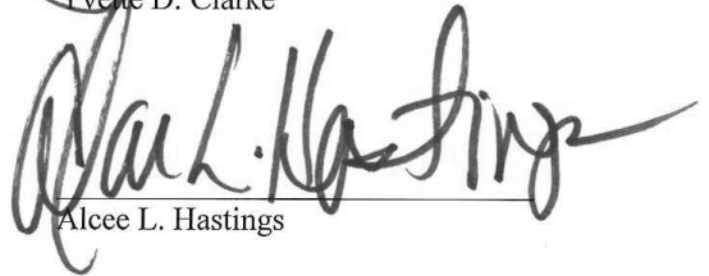

Linda T. Sánchez



Walter B. Jones Jr.



Albio Sires


Yvette D. Clarke


Leonard Lance


Alcee L. Hastings


Brendan F. Boyle

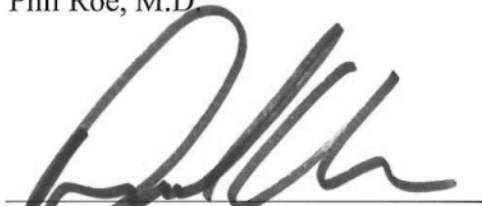

Kathy Castor



Robert Dold


Richard E. Neal


Phil Roe, M.D.

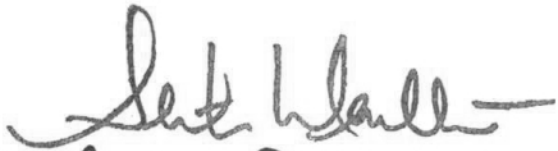

Suzanne Bonamici



David G. Valadao

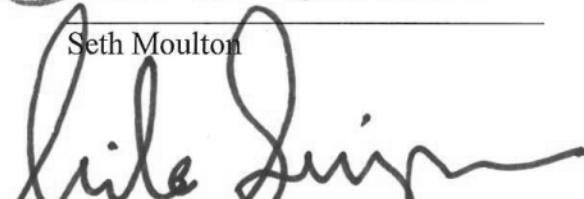

Chris Collins


Sam Farr


Bill Huizenga



Seth Moulton


Sam Johnson


Mike Simpson


Mike Fitzpatrick


Austin Scott


Kristi Noem

Cathy McMorris Rodgers

Cathy McMorris Rodgers



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Henry C. "Hank" Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

Earlier this year, we published a preliminary recommendation on CMS's official HCPCS Website at: <http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCS-Public-Meeting-Agenda.pdf>, indicating that existing HCPCS codes for intermittent urinary catheters adequately describe catheters with hydrophilic coating.

The CMS has carefully considered the application as well as all of the related public comments received as part of the May 28th HCPCS public meeting and additional input provided to CMS staff at a meeting on August 14, 2014. The HCPCS Workgroup has made a final determination regarding this application that the existing codes adequately describe the product. With regard to the Medicare program, there is no program need to establish separate codes in this instance since there are currently no national or local coverage determinations that differentiate intermittent urinary catheters based on the types of materials used in the manufacture of the intermittent urinary catheter. Hydrophilic-coated catheters will remain in the existing HCPCS code for calendar year 2015.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening Medicare for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable David Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Doug Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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I appreciate your interest in this important issue as we work toward our mutual goal of strengthening Medicare for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Lynn Westmoreland
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westmoreland:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Phil Gingery, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingery:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Paul C. Broun
U.S. House of Representatives
Washington, DC 20515

Dear Representative Broun:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable John Lewis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lewis:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

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Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Sanford Bishop, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

Earlier this year, we published a preliminary recommendation on CMS's official HCPCS Website at: <http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCS-Public-Meeting-Agenda.pdf>, indicating that existing HCPCS codes for intermittent urinary catheters adequately describe catheters with hydrophilic coating.

The CMS has carefully considered the application as well as all of the related public comments received as part of the May 28th HCPCS public meeting and additional input provided to CMS staff at a meeting on August 14, 2014. The HCPCS Workgroup has made a final determination regarding this application that the existing codes adequately describe the product. With regard to the Medicare program, there is no program need to establish separate codes in this instance since there are currently no national or local coverage determinations that differentiate intermittent urinary catheters based on the types of materials used in the manufacture of the intermittent urinary catheter. Hydrophilic-coated catheters will remain in the existing HCPCS code for calendar year 2015.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening Medicare for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Marilyn Tavenner



DEC 19 2014

Administrator
Washington, DC 20201

The Honorable Jack Kingston
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kingston:

Thank you for your letter regarding hydrophilic-coated intermittent urinary catheters, used by persons who have permanent bladder impairment. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS received an application requesting that we revise the language of existing Healthcare Common Procedure Coding System (HCPCS) codes to exclude hydrophilic-coated catheters, and create new codes to uniquely describe hydrophilic-coated catheters. This application was given careful consideration. CMS maintains a HCPCS coding process that allows for public input, and due diligence is paid to all HCPCS code applications. The HCPCS workgroup conducts a thorough review of requests for new codes before CMS makes final decisions. Our coding process includes publication of preliminary coding decisions on CMS's HCPCS Website and annual public meetings that provide all HCPCS code applicants and the general public an opportunity to provide input regarding code applications and comments on published preliminary coding decisions.

Earlier this year, we published a preliminary recommendation on CMS's official HCPCS Website at: <http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCS-Public-Meeting-Agenda.pdf>, indicating that existing HCPCS codes for intermittent urinary catheters adequately describe catheters with hydrophilic coating.

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I appreciate your interest in this important issue as we work toward our mutual goal of strengthening Medicare for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner". The signature is written in black ink and is positioned above the printed name.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

September 22, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 337 Hubert Humphrey Building
Washington, DC 20201

Dear Administrator Tavenner:

We are writing to urge the Centers for Medicare and Medicaid Services (CMS) to ensure access to hydrophilic-coated catheters for individuals with Spinal Cord Injury (SCI), Spina Bifida (SB), Muscular Sclerosis (MS), and others who suffer from permanent impairment of their bladder and urinary system, with no expectation of medical or surgical correction.

One of the most troubling and significant causes of morbidity and mortality for these individuals is inadequate bladder management. People with a neurogenic bladder suffer both urinary retention and incontinence which can lead to potentially life threatening urinary tract infections (UTI) because of this dysfunction. Access to Hydrophilic-Coated Catheters is important for patients to avoid UTIs and maintain their quality of life.

It has been brought to our attention that CMS has denied an application for separate, unique Healthcare Procedure Coding System (HCPCS) codes for Hydrophilic-Coated Catheters, effective January 1, 2015. We understand that without these distinct HCPCS codes, patients cannot be assured access to Hydrophilic-Coated Catheters at the supplier level and that it is challenging to conduct outcomes-based research regarding the provision of high quality care and avoidance of life threatening UTI infections. Therefore, we ask that CMS continue to work with the healthcare community to address this national health policy imperative, including the assignment of separate HCPCS codes by type of catheter.

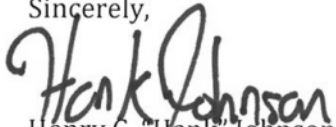
As you may know, Hydrophilic-Coated Catheters differ greatly from Uncoated Catheters due to their distinct "slippery" coating. This coating is a technologically advanced layer of polymer bound to the catheter surface, consisting of Polyvinyl Pyrrolidone, salt and Polyvinyl Chloride – which enables the outer layer of the catheter to become smooth when hydrated, resulting in a nearly friction-free intermittent catheter insertion and withdrawal. This minimizes the risk of any catheter-related trauma, bleeding, and damage to the urethra and/or sphincter – all well documented as directly contributing risks for an UTI infection.

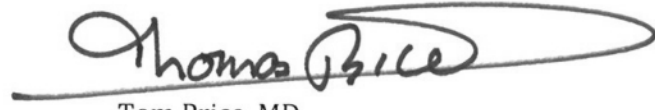
For the patient population, the medical benefit of Hydrophilic-Coated Catheters is far reaching. Evidence showing the efficacy and patient benefit of Hydrophilic-Coated Catheters versus uncoated has been referenced in multiple studies. For the healthcare system, Hydrophilic-Coated Catheters represent an overall reduction in costs associated with ER visits and hospitalization related to the treatment of UTIs.


We would appreciate CMS' assistance, including working with the medical community to re-review and approve new HCPCS codes for Hydrophilic-Coated Catheters, effective January 1, 2015.

We look forward to your response.

Sincerely,

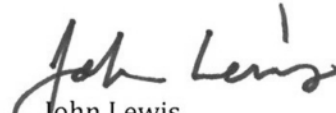

Henry C. "Hank" Johnson
Member of Congress


Tom Price, MD
Member of Congress

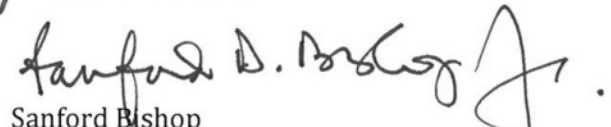

David Scott
Member of Congress

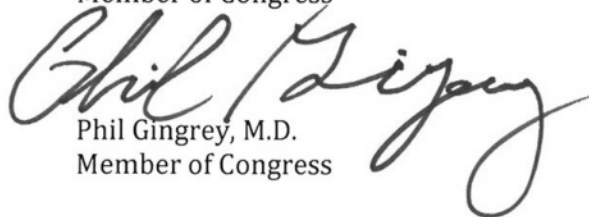

Paul C. Broun
Member of Congress


Doug Collins
Member of Congress


John Lewis
Member of Congress


Lynn Westmoreland
Member of Congress


Sanford Bishop
Member of Congress


Phil Gingrey, M.D.
Member of Congress


Jack Kingston
Member of Congress



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Michael C. Burgess
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide a copy of this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Andy Harris
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harris:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable David B. McKinley
U.S. House of Representatives
Washington, DC 20515

Dear Representative McKinley:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Gus Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Phil Gingrey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Dan Benishek
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Andy Barr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barr:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Pete Olson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Olson:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Marilyn Taverner



Administrator
Washington, DC 20201

OCT 17 2014

The Honorable Ed Whitfield
U.S. House of Representatives
Washington, DC 20515

Dear Representative Whitfield:

Thank you for your letter regarding our proposal to bundle payment for imaging guidance with payment for epidural injections in the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

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Sincerely,

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Marilyn Tavenner

Congress of the United States
Washington, DC 20515

September 23, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Tavenner:

We write today to raise concerns in regard to the Centers for Medicare and Medicaid Services' (CMS) proposal to prohibit the separate reporting of imaging guidance codes in conjunction with the Current Procedural Terminology (CPT) codes 62310, 62311, 62318, 62319, pertaining to caudal and lumbar interlaminar, cervical, and thoracic interlaminar epidural injections with or without catheterization. Separately, we would also ask CMS to use its authority to permit retroactive reimbursement for these procedures for 2014.

Last year, many congressional offices expressed concern over the valuation of the above services for 2014. We are pleased that CMS has acknowledged our concerns about the valuation of these services for 2014 and has presented a process to address them for 2015 and beyond. In its most recent guidance, CMS proposed to return to the 2013 work values and practice expense resources for 2015 and to gather data to determine how to most accurately value these important services – with any associated imaging guidance – for future years. Since CMS has determined that it is appropriate to reverse the changes, we ask that you retroactively reimburse physicians for these procedures beginning January 1, 2014.

While we commend CMS for reversing the decrease of the relative value units that was implemented for 2014, the prohibition to report any imaging guidance used with epidural injection codes is of concern. We ask you to permit the separate reporting of imaging guidance for CY2015, thereby offering healthcare professionals and CMS the opportunity to produce the information related to the use of imaging with these services. This information will better assist the agency to accurately value these services in the context of current practice.

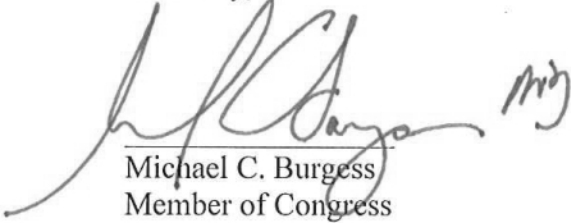
In short, we ask you to permit retroactive reimbursement and also allow separate reporting of image guidance codes in conjunction with the above listed epidural injection codes in your final rule for the CY2015 Medicare Physician Fee Schedule. Thank you for your attention to this matter. We believe valuing these codes correctly is important to the treatment and safety of patients with chronic pain.


Letter to the Honorable Marilyn Tavenner


Page 2

We appreciate your consideration. Should you have any questions, please contact Katie Allen in Representative Burgess' office at Kathryn.Allen@mail.house.gov.


Sincerely,



Michael C. Burgess
Member of Congress


Andy Harris
Member of Congress



Renee Elmers
Member of Congress



Ed Whitfield
Member of Congress


David B. McKinley
Member of Congress


Gus Bilirakis
Member of Congress


Phil Gingrey
Member of Congress

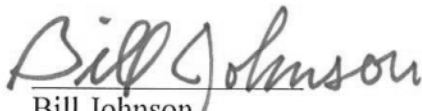

Dan Benishek
Member of Congress


Andy Barr
Member of Congress


Tom Price
Member of Congress


Pete Olson
Member of Congress


Brett Guthrie
Member of Congress


Bill Johnson
Member of Congress



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable David B. McKinley, P.E.
U.S. House of Representatives
Washington, DC 20515

Dear Representative McKinley:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Section 3131(a) of the Affordable Care Act requires that starting in CY 2014, the Secretary must apply an adjustment to rebase the home health payment rates to reflect factors such as changes of the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, the provision requires that this rebasing be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the home health payment amount in any given year, and be fully implemented by CY 2017.

We appreciate your concerns regarding the data used in establishing the proposed rebasing adjustment. We will carefully consider all comments received during the comment period before making final policy decisions and publishing a final rule. CMS will include its decisions in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued in November of 2013.

Our program priorities are to ensure access and high quality of care to Medicare beneficiaries. We will be closely monitoring the impact of the changes finalized in the CY 2014 Home Health PPS rule on Medicare beneficiaries. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also send this letter to the co-signers of your letter.

Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Doris Matsui
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Earl Blumenauer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blumenauer:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Walter Jones
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jones:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Raul Ruiz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ruiz:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Todd Rokita
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rokita:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Dan Benishek
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Jim Gerlach
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gerlach:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kind:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bill Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable H. Morgan Griffith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffith:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Trey Radel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Radel:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael Burgess
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bob Gibbs
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gibbs:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable James McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bill Shuster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Shuster:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Blake Farentold
U.S. House of Representatives
Washington, DC 20515

Dear Representative Farentold:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mark Amodei
U.S. House of Representatives
Washington, DC 20515

Dear Representative Amodei:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael Honda
U.S. House of Representatives
Washington, DC 20515

Dear Representative Honda:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grisham:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lynn Westmoreland
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westmoreland:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lou Barletta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barletta:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tony Cardenas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cardenas:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tim Griffin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffin:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Sean Duffy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duffy:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Eddie Bernice Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bill Flores
U.S. House of Representatives
Washington, DC 20515

Dear Representative Flores:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable John F. Tierney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tierney:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lamar Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ann M. Kuster
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kuster:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bruce L. Braley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Braley:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Louise McIntosh Slaughter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Slaughter:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable David Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Shelly Moore Capito
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capito:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ralph M. Hall
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hall:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Gene Green
U.S. House of Representatives
Washington, DC 20515

Dear Representative Green:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Alan Nunnelee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunnelee:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable E. Scott Rigell
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rigell:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable John Larson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Larson:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Pete Sessions
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sessions:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Elijah E. Cummings
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cummings:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable James R. Langevin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Langevin:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Juan Vargas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Vargas:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Joe Garcia
U.S. House of Representatives
Washington, DC 20515

Dear Representative Garcia:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lucille Roybal-Allard
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roybal-Allard:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tammy Duckworth
U.S. House of Representatives
Washington, DC 20515

Dear Representative Duckworth:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ami Bera
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bera:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Kenny Marchant
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marchant:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mac Thornberry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thornberry:

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tim Walberg
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walberg:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Peter T. King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael K. Conaway
U.S. House of Representatives
Washington, DC 20515

Dear Representative Conaway:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Andy Barr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barr:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Joseph P. Kennedy, III
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kennedy:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Nich J. Rahall, II
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rahall:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Henry Cuellar
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cuellar:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Niki Tsongas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tsongas:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Patrick J. Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

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Sincerely,

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael H. Michaud
U.S. House of Representatives
Washington, DC 20515

Dear Representative Michaud:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tom Marion
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marion:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stivers:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Harold Rogers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Matthew A. Cartwright
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cartwright:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Steven Israel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Israel:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ben Ray Jujan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Jujan:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mike Coffman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Coffman:

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Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable J. Randy Forbes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Forbes:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Susuan W. Brooks
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brooks:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Julia Brownley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brownley:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Linda T. Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable Tom Lathan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lathan:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Randy Neugebauer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neugebauer:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Marc A. Veasey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Veasey:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable David G. Reichert
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reichert:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mike Rogers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Chellie Pingree
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pingree:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Joe Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable Tulsi Gabbard
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gabbard:

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Sincerely,

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Derek Kilmer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kilmer:

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Sincerely,

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ron Barber
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barber:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Loretta Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Rick Crawford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crawford:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Steven A. Horsford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Horsford:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Paul Tonko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tonko:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Joseph Crowley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crowley:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ed Whitfield
U.S. House of Representatives
Washington, DC 20515

Dear Representative Whitfield:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Peter Welch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Welch:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Ileana Ros-Lehtinen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ros-Lehtinen:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Lee Terry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Terry:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Sam Farr
U.S. House of Representatives
Washington, DC 20515

Dear Representative Farr:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Stephen F. Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Dina Titus
U.S. House of Representatives
Washington, DC 20515

Dear Representative Titus:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Jim Matheson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matheson:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Tom Reed
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reed:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Pete P. Gallego
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gallego:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable David P. Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Scott R. Tipton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tipton:

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael G. Fitzpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fitzpatrick:

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Grace F. Napolitano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Napolitano:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Joaquin Castro
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castro:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Kyrsten Sinema
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sinema:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Renee L. Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michele Bachmann
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bachmann:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable Thomas J. Rooney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rooney:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable John R. Carter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carter:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Robert Hurt
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hurt:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Colleen W. Hanabusa
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanabusa:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Adam B. Schiff
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schiff:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Gus M. Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Jon Runyan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Runyan:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Vern Buchanan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Jackie Speier
U.S. House of Representatives
Washington, DC 20515

Dear Representative Speier:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Frank A. LoBiondo
U.S. House of Representatives
Washington, DC 20515

Dear Representative LoBiondo:

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Christopher H. Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Anna G. Eshoo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Eshoo:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Al Green
U.S. House of Representatives
Washington, DC 20515

Dear Representative Green:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable William L. Owens
U.S. House of Representatives
Washington, DC 20515

Dear Representative Owens:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Charles B. Rangel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rangel:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Grace Meng
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meng:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 29 2013

Administrator
Washington, DC 20201

The Honorable William R. Keating
U.S. House of Representatives
Washington, DC 20515

Dear Representative Keating:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

OCT 29 2013

The Honorable Lois Frankel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Frankel:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Phil Gingrey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Zoe Lofgren
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lofgren:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Michael T. McCaul
U.S. House of Representatives
Washington, DC 20515

Dear Representative McCaul:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Gary C. Peters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



OCT 29 2013

Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding the calendar year (CY) 2014 Home Health Prospective Payment System (HH PPS) rule. The HH PPS proposed rule was issued on June 27, 2013, with a 60-day comment period that ended on August 26, 2013. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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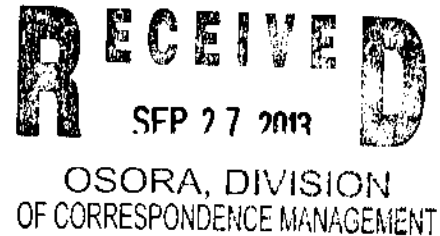
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Congress of the United States
Washington, DC 20515

Due - 10/11/13

September 25, 2013

Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



Dear Administrator Tavenner,

We are writing today to express our deep concern with the proposed 2014 Home Health Prospective Payment System (HHPPS) rule and its proposed implementation of the rebasing provision in Section 3131 of the Affordable Care Act (ACA).

Home health is a critical service that allows patients to be treated in a cost-effective manner in the environment they prefer – their home. Home health patients are among the most vulnerable in the Medicare program, being older, sicker and poorer than the general Medicare population. As a result, access to home healthcare services is essential, as it enables vulnerable seniors to receive the medical treatment they need in the cost-effective setting that they prefer most.

Therefore we are concerned about the draft HHPPS rule's proposal to cut Medicare home health funding by a total of 14 percent over 4 years (3.5% reduction each year in 2014-2017). It has been projected that if the proposed rule is finalized in its current form, Medicare reimbursement for home health services will be driven below cost in every State by 2017. As a result, we are concerned that the proposed rule would have a direct impact on access for millions of seniors, many of whom reside in rural and underserved communities. A significant amount of this care in rural and underserved areas is provided by thousands of small businesses that would be most at risk of going out of business under the proposed rule.

We firmly believe in ensuring that Medicare payments are based on the best available data. However, we are concerned that the proposed rule may fall short of this goal due to its reliance on incomplete data. Consequently we believe that the analysis results in the under-counting of home health agencies' costs, an over-estimation of their operating margins and, as a result, an inappropriately high rebasing adjustment.

For example, the proposed rule appears to under-estimate agencies' actual operating costs by excluding costs that are routinely borne by home health providers. Home health agencies are increasingly utilizing telehealth technologies, but their cost is excluded from the proposed rule's calculations of the cost per episode of care. Similarly, costs that agencies must bear as a result of taxes and regulations, such as regulatory compliance and the payment of federal, state and local taxes, also appear to be excluded. Finally, the overhead costs of hospital-based home health

agencies do not seem to be adequately factored into the rule's calculations, since those agencies face particularly deep losses as a result of this rule.

The Medicare home health benefit has experienced a series of funding reductions since 2009 that are reducing reimbursement by more than 20 percent over a 10-year period. In order to ensure the sustainability of any additional cuts, it is both critical and required under statute and Executive Orders that the impact of current law reductions be fully taken into account in a multi-year analysis if the payment cuts are to apply over several years

President Obama's Executive Order 13563, "Improving Regulation and Regulatory Review", directs agencies to use the "best available techniques to quantify present and future benefits and costs as accurately as possible." The draft HIIPPS rule provides only a partial impact assessment for only one year (2014), even though the ACA directs that this provision be implemented over four years (2014-2017). At the same time, the draft rule fails to take into account revenue reductions that will impact agencies in the years to come, such as productivity adjustments and sequestration.

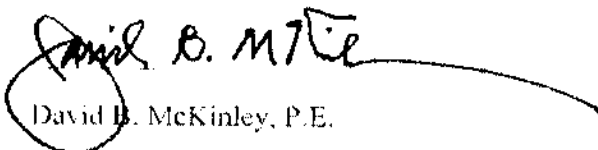
As a result of these factors, we respectfully request the Agency's analysis of the impact of this rule on beneficiaries, the national delivery system, each state, and small businesses be performed in each of the four years in which the rebasing adjustment is to take effect. We also ask that CMS utilize a more current and complete data set to fully account for the operating costs that are routinely borne by home health providers.

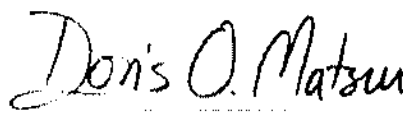
In closing, we wish to express our concern that -- if finalized in its current form -- the proposed rule is projected to drive Medicare reimbursement below costs in all states across the country and have a significant impact on some of the most vulnerable Medicare seniors and the communities in which they live.

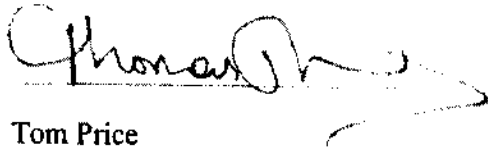
We are committed to the goal of ensuring fair and accurate payment for Medicare services, which is why we urge you to include all routinely-borne operating costs in the proposed rule and conduct a detailed four-year impact analysis in order to ensure seniors' continued access to home health in every State.

We thank you for your attention to this critical matter.

Sincerely,


David B. McKinley, P.E.

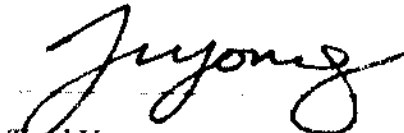

Doris Matsui



Tom Price



Earl Blumenauer



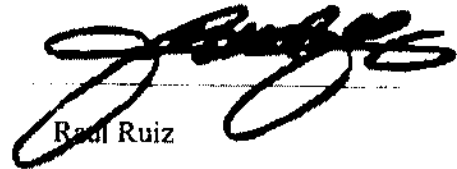
Todd Young



Walter Jones




Marsha Blackburn




Raul Ruiz



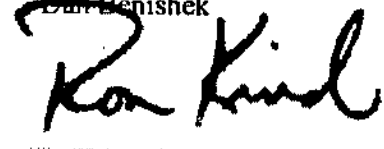
Todd Rokita



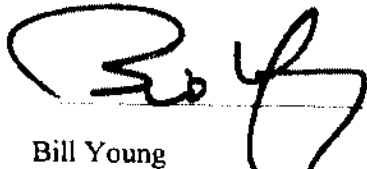
Dan Benishek



Jim Gerlach



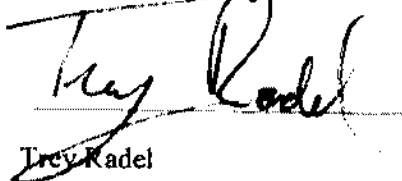
Ron Kind



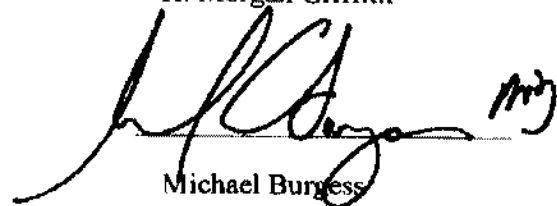
Bill Young



H. Morgan Griffith



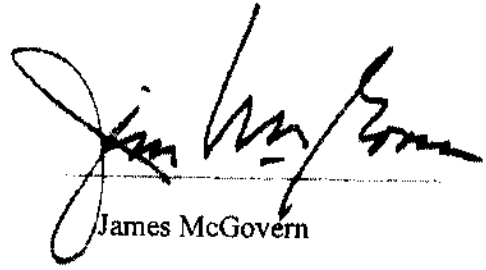
Trey Radel



Michael Burgess



Bob Gibbs



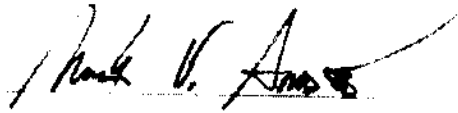
James McGovern



Bill Shuster



Blake Farenthold



Mark Amodei



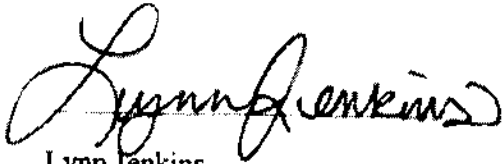
Michael Honda



Michelle Lujan Grisham



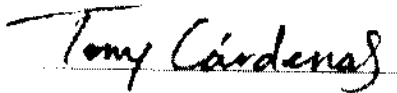
Lynn Westmoreland



Lynn Jenkins



Lou Barletta



Tony Cardenas



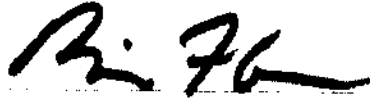
Tim Griffin



Sean Duffy



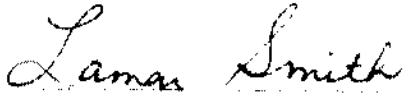
Eddie Bernice Johnson



Bill Flores



John F. Tierney



Lamar Smith



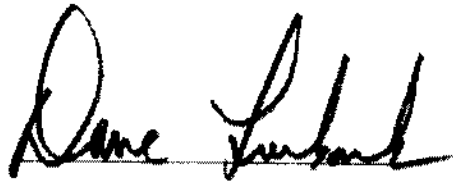
Ann M. Kuster



Bruce L. Braley



Louise McIntosh Slaughter



David Loeb sack



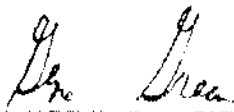
Shelley Moore Capito



Bill Johnson



Ralph M. Hall



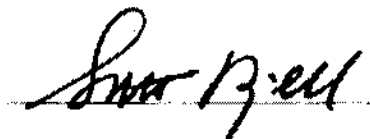
Gene Green



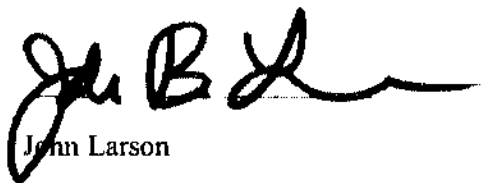
Mike Thompson



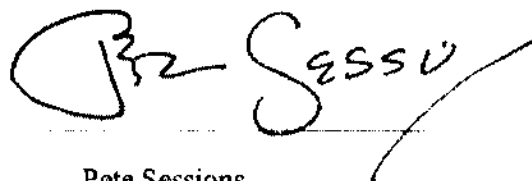
Alan Nunnelee



E. Scott Rigell



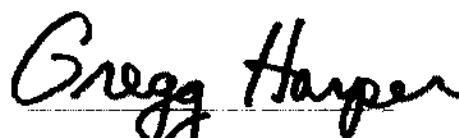
John Larson



Pete Sessions



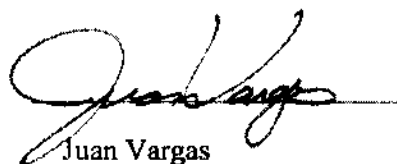
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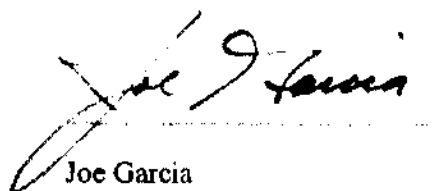
Gregg Harper



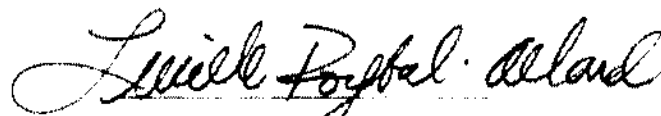
James R. Langevin



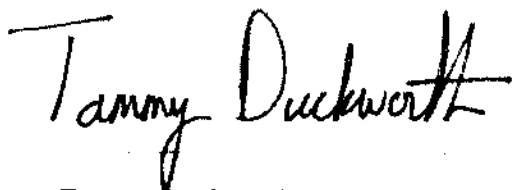
Juan Vargas



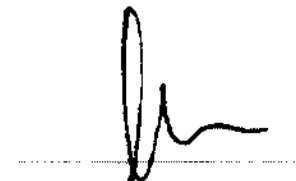
Joe Garcia



Lucille Royal-Allard



Tammy Duckworth



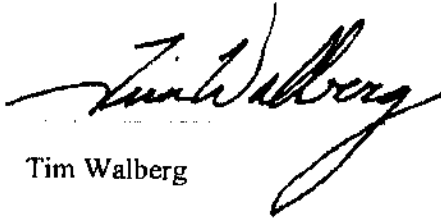
Ami Bera



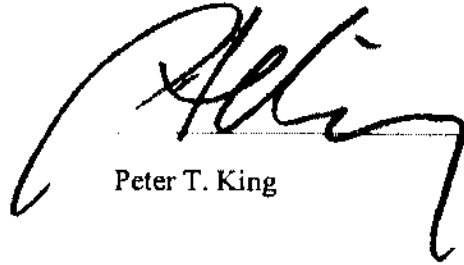
Kenny Marchant



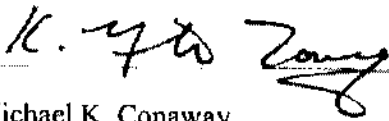
Mac Thornberry



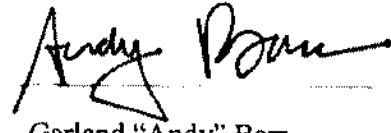
Tim Walberg



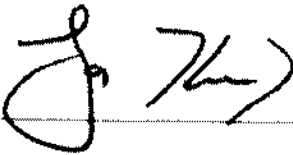
Peter T. King



Michael K. Conaway



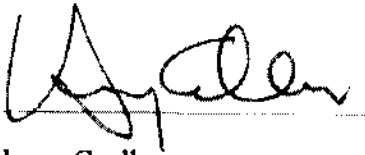
Garland "Andy" Barr



Joseph P. Kennedy, III



Nick J. Rahall, II



Henry Cuellar



Brett Guthrie



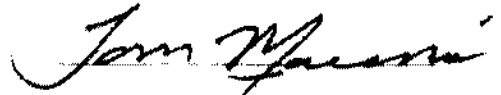
Niki Tsongas



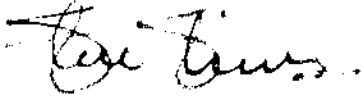
Patrick J. Tiberi



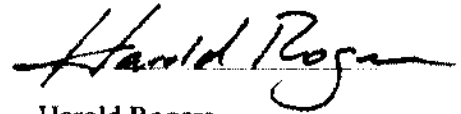
Michael H. Michaud



Tom Marino



Steve Stivers



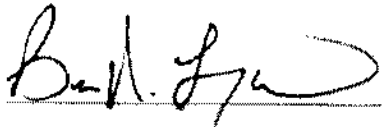
Harold Rogers




Matthew A. Cartwright




Steve Israel



Ben Ray Lujan



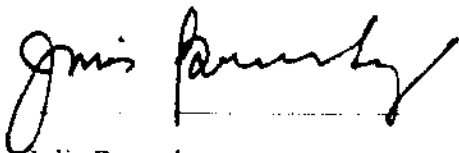
Mike Coffman



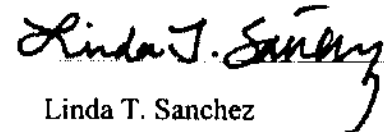
J. Randy Forbes



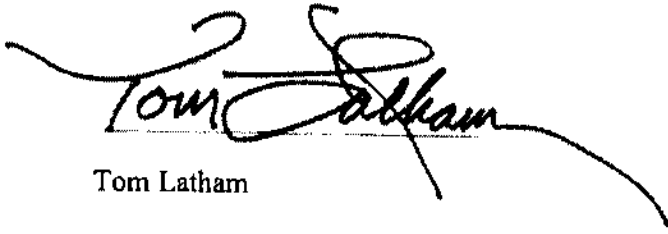
Susan W. Brooks

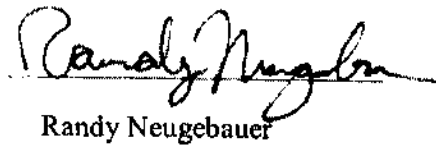


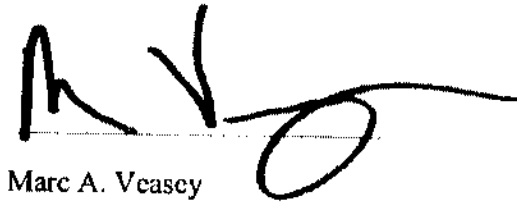
Julia Brownley

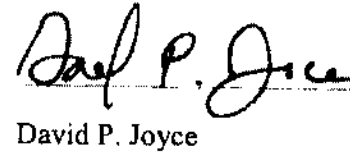


Linda T. Sanchez

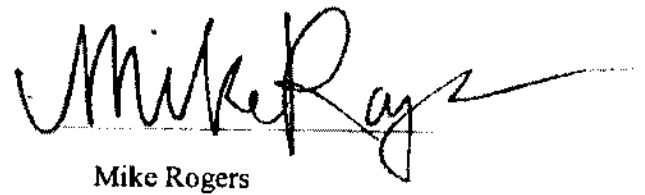

Tom Latham

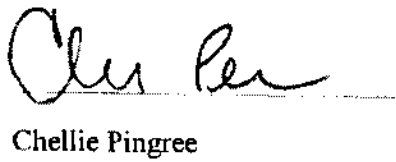

Randy Neugebauer

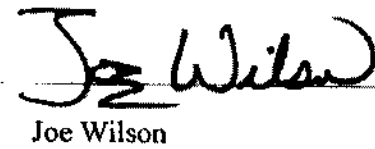

Marc A. Veasey

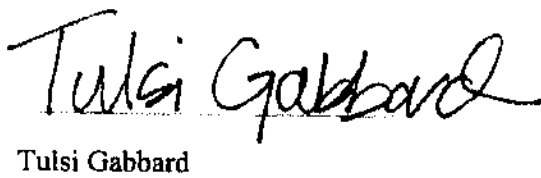

David P. Joyce


David G. Reichert

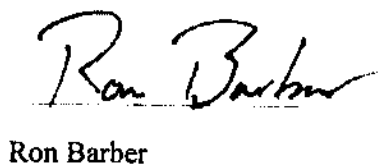

Mike Rogers



Chellie Pingree


Joe Wilson


Tulsi Gabbard

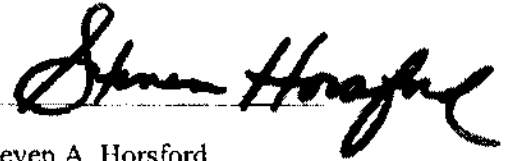

Derek Kilmer


Ron Barber


Loretta Sanchez



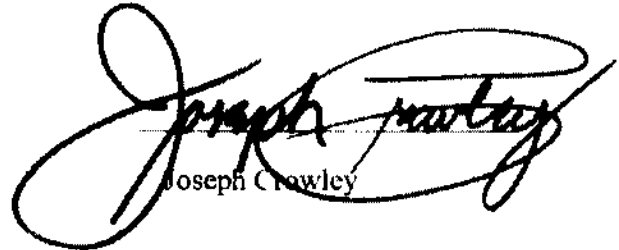
Rick Crawford



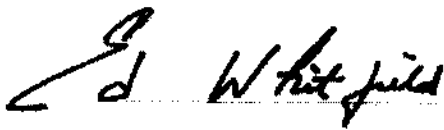
Steven A. Horsford



Paul Tonko



Joseph Crowley



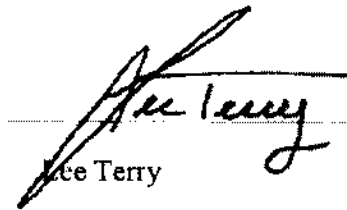
Ed Whitfield



Peter Welch



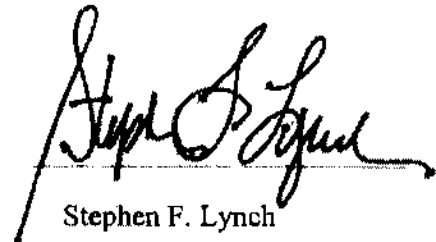
Ileana Ros-Lehtinen



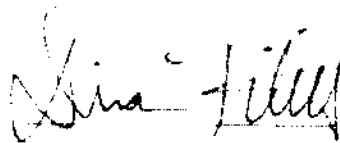
Lee Terry



Sam Farr



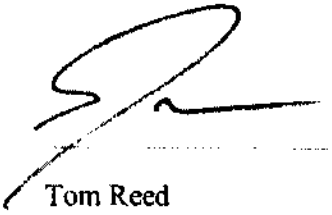
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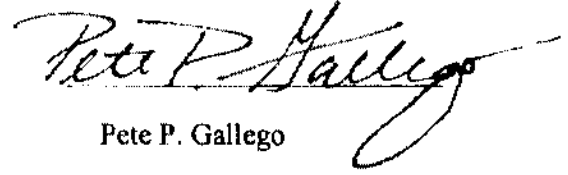
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Jim Matheson



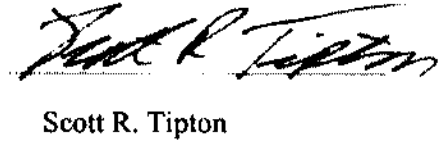
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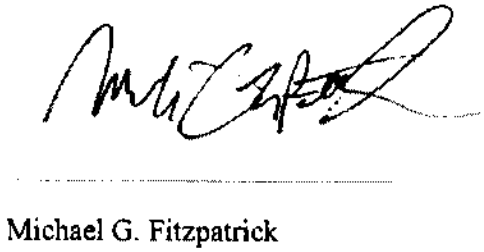
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David P. Roe



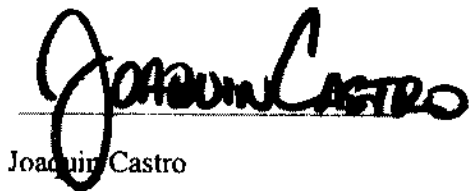
Scott R. Tipton



Michael G. Fitzpatrick



Grace F. Napolitano



Joaquin Castro



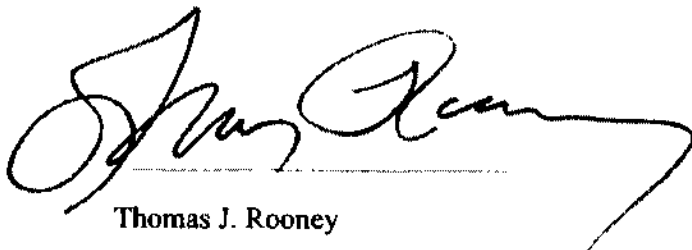
Kyrsten Sinema



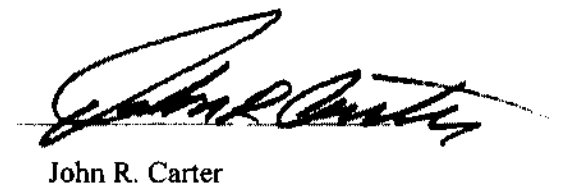
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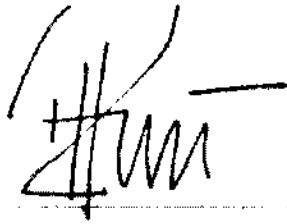
Michele Bachmann



Thomas J. Rooney



John R. Carter



Robert Hurt



Colleen W. Hanabusa



Adam B. Schiff



Mike Kelly




Gus M. Bilirakis



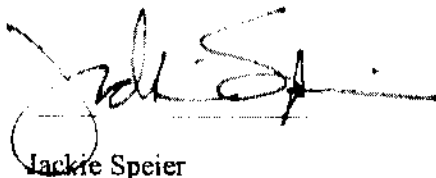
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Vern Buchanan



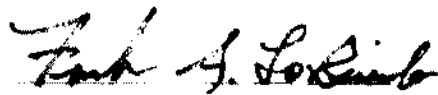
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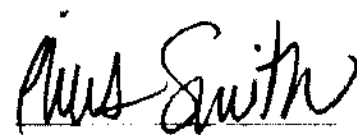
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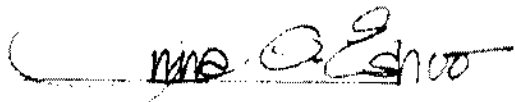
Leonard Lance



Frank A. LoBiondo



Christopher H. Smith



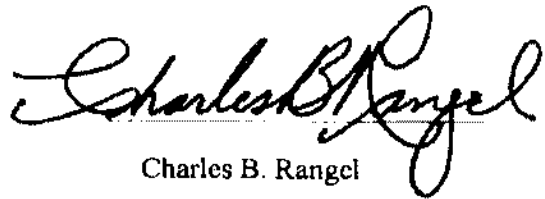
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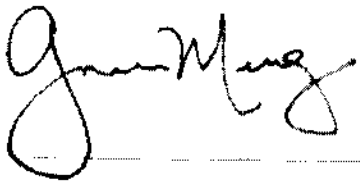
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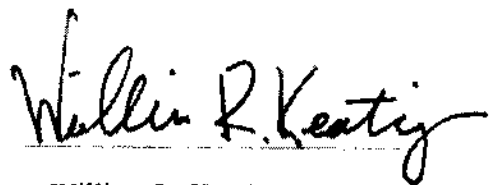
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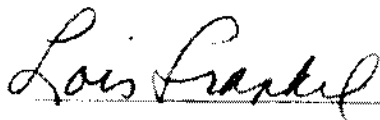
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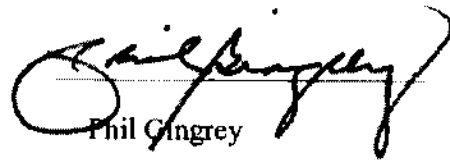
Grace Meng



William R. Keating



Lois Frankel



Phil Gingrey



Zoe Lofgren



Michael T. McCaul



Gary C. Peters



Chris Collins



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Phil Gingrey, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Charles Boustany, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Boustany:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Scott Desjarlais
U.S. House of Representatives
Washington, DC 20515

Dear Representative Desjarlais:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

OCT 16 2012

The Honorable Paul Gosar, D.D.S.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gosar:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Joe Heck, D.O.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Heck:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

OCT 16 2012

The Honorable Phil Roe, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Dan Benishek, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Paul Broun, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Broun:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Bill Cassidy, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cassidy:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable John Fleming, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleming:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Andy Harris, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harris:

Thank you for your letter regarding proposed changes to Medicare payment for certified nurse anesthetists' services paid under the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The Calendar Year (CY) 2013 Medicare Physician Fee Schedule proposed rule was issued on July 6, 2012, with a 60-day comment period that ended on September 4, 2012. We appreciate your concerns and will carefully consider all comments received during the comment period before making a final policy decision and publishing the final rule. CMS will include its decision in the final regulation, along with a summary of the comments and our responses. We anticipate addressing this and other issues as part of establishing Medicare's CY 2013 Physician Fee Schedule.

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Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

OCT 16 2012

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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Marilyn Tavenner
Acting Administrator

Congress of the United States
Washington, DC 20515

09282012 4017
Due - 10/15/12

September 24, 2012

RECEIVED
SEP 28 2012
OSORA, DIVISION
OF CORRESPONDENCE MANAGEMENT

Marilyn B. Tavenner
Acting Administrator, Chief Operating Officer
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, CY 2013

Dear Acting Administrator Tavenner:

As members of the GOP Doctors Caucus, we write regarding the Centers for Medicare and Medicaid Services (CMS) recent Notice for Proposed Rulemaking (NPRM) that would open the door for Certified Registered Nurse Anesthetists (CRNA) to bill Medicare directly for chronic pain management services as part of the physician fee schedule. While we all support the goals of improving access to quality care, we believe this proposal would do the opposite by mandating Medicare coverage of providers with no education or training in the medical specialty of pain management. Multiple agency studies have shown issues in those areas (HHS-OIG OEI-05-09-00030, OEI-05-07-00200, and GAO OEI-09-06-00430). It also appears that none of the stakeholders were involved in framing the regulation.

Interventional pain management (IPM) is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment. Most interventional pain physicians have completed post residency fellowship training and/or approved board certification in the specific field of IPM for 1-3 years. Other physicians treating chronic pain receive additional training, mentoring and education outside of a formal fellowship. Either way, all interventional pain physicians have received the usual 12 years or more of education and training to achieve a designated medical specialty such as Anesthesiology, Physical Medicine and Rehabilitation, Neurology, Psychiatry, or Surgery.

On the other hand, there is no evidence that chronic pain management is a part of nurse anesthetists' education and training. In fact, the Noridian policy on "CRNA Practice and Chronic Pain Management" states, "The assessment skills required for the evaluation of the chronic pain state and consequent therapy are not part of the CRNA training curricula." Additionally, the lack of training of nurse anesthetists in chronic pain management was a major point of discussion in a Louisiana court decision in 2008 (*Spine Diagnostics Center of Baton Rouge v. Louisiana State Board of Nursing*). Per the sworn testimony of Jackie Rowles (past-president of the American Association of Nurse Anesthetists) CRNAs do not maintain any guidelines for assessing the competency, skill set, abilities, or training needed in order to perform chronic interventional pain management procedures.

The responsibility of medical regulation is to ensure safety and efficacy for patients who seek care but may not understand the vast differences in training and skill among health care providers and medical treatments. The U.S. medical education system and credentialing process seeks to ensure that all physician providers possess an acceptable level of competency and safety through an arduous course of extensive medical training, broad based patient care responsibilities, mentored specialty training, critical oral, written and hands-on specialty board certification as well as ongoing medical education and specialty re-certification.

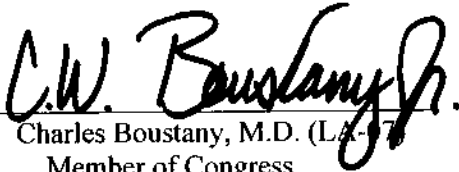
We urge CMS to reconsider its proposal to allow CRNAs to bill Medicare directly for chronic pain management services when the final rule is published as it is not in the best interest of patients. Thank you for your attention to this important matter.



Phil Gingrey, M.D. (LA-11)
Member of Congress




Dan Benishke, M.D. (MI-01)
Member of Congress



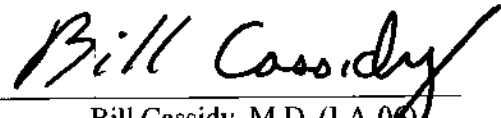
Charles Boustany, M.D. (LA-07)
Member of Congress



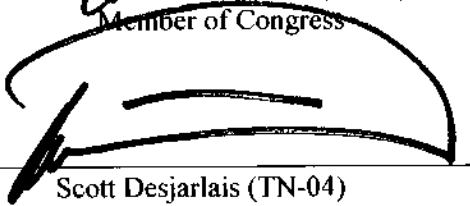
Paul Brown, M.D. (GA-10)
Member of Congress



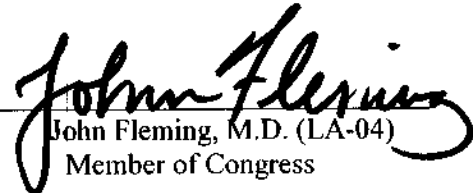
Larry Bucshon, M.D. (IN-08)
Member of Congress



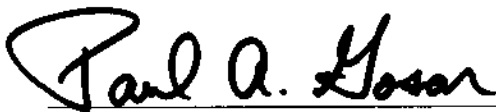
Bill Cassidy, M.D. (LA-06)
Member of Congress



Scott Desjarlais (TN-04)
Member of Congress



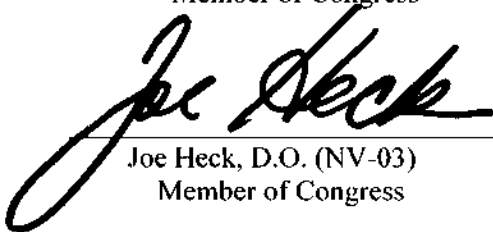
John Fleming, M.D. (LA-04)
Member of Congress



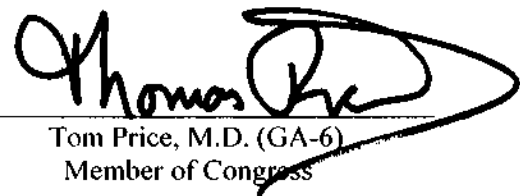
Paul Gosar, D.D.S. (AZ-01)
Member of Congress



Andy Harris, M.D. (MD-01)
Member of Congress



Joe Heck, D.O. (NV-03)
Member of Congress



Tom Price, M.D. (GA-6)
Member of Congress



Phil Roe, M.D. (TN-01)
Member of Congress



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Michael C. Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

We understand your concerns and welcome the suggestions you made regarding reporting under the QCDR option. In response to your first request, please note that the criteria we proposed for satisfactory participation in a QCDR would, if finalized, apply to the 2017 PQRS payment adjustment and beyond. We will take all comments, including yours, into careful consideration when developing the final requirements for meeting the criteria for satisfactory participation in a QCDR for the 2017 PQRS payment adjustment. Please note that the final requirements for the QCDR option will be published in the CY 2015 PFS final rule.

With respect to your second request, since the establishment of the QCDR option in the American Taxpayer Relief Act of 2012 (ATRA), we have actively engaged with stakeholders as we have developed policies and requirements for the QCDR option. We will continue to work closely with these stakeholders as we develop requirements for the 2018 PQRS payment adjustment and beyond. We hope continued collaboration with outside stakeholders will encourage use of the QCDR option in the future, which we believe will help to promote quality, efficiency, and value in the care provided to patients.

We sincerely thank you for your interest in the QCDR requirements. Please do not hesitate to contact me if you have additional questions. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Gene Green
U.S. House of Representatives
Washington, DC 20515

Dear Representative Green:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Sincerely,

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Ami Bera, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bera:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Sincerely,

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Marilyn Tavenner



NOV 23 2014

Administrator
Washington, DC 20201

The Honorable Bill Pascrell, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pascrell:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Phil Roe, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Paul Tonko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tonko:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Sincerely,

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Marilyn Tavenner



NOV 20 2014

Administrator
Washington, DC 20201

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

Thank you for your letter regarding the Qualified Clinical Data Registry (QCDR) option in the Physician Quality Reporting System (PQRS). In your letter, you express concern regarding the changes we proposed to make in the QCDR option in the Calendar Year (CY) 2015 Physician Fee Schedule (PFS) proposed rule. Specifically, you request that we maintain the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment for at least one additional year. In addition, you request that we propose a new pathway model for reporting quality measures data under the QCDR option in the CY 2016 rule based on clinical data registry stakeholder input.

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Marilyn Tavenner

Congress of the United States
Washington, DC 20515

September 26, 2014

Marilyn B. Tavenner, MHA, BSN, RN
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner,

As Members of Congress, we are excited about the potential clinical data registries have to improve quality and efficiency of health care as well as play an important role in cutting health costs in the future. Registries are a key element of the quality-based payment system contained in the bi-partisan legislation to repeal and replace Medicare's sustainable growth rate (SGR) formula, and we should be working together to promote their widespread adoption. Unfortunately, it has come to our attention that certain provisions of the Proposed 2015 Medicare Physician Fee Schedule Rule could create barriers to the development and success of qualified clinical data registries (QCDRs). We know many physician specialty organizations share our concerns over the potential negative impact the proposed fee schedule could have on the successful development of QCDRs. Therefore, we urge you and your staff to carefully consider these concerns and work with the Congress and registry community to ensure QCDRs reach their full potential.

The American Taxpayer Relief Act (ATRA) of 2012 recognized the tremendous opportunity to leverage clinical data registries to measure and improve health care through a process whereby physicians participating in a QCDR are "deemed" to have satisfied quality reporting requirements under the Physician Quality Reporting System (PQRS). The law also enables QCDRs to develop and report on non-PQRS measures for QCDR participants in the PQRS program.

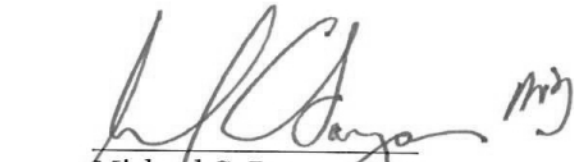
However, the proposals included in the proposed 2015 fee schedule may discourage eligible professionals from participating in QCDRs, stunting the growth of these promising vehicles of innovation. The proposed rule includes a number of changes to the PQRS program, including a significant increase in reporting requirements for QCDR participants. CMS is proposing to move from requiring that all participants report on one outcome measure to three outcome measures - just after the QCDRs' first year in operation. This proposal will preclude subspecialists who do not have even two outcome measures available to report from participating in a QCDR. Also, the proposed requirement to publicly report on all 2015 QCDR data in 2016, including first year performance data on newly developed QCDR measures, will discourage many providers from participating in QCDRs. First year data will not depict an accurate view of performance, as there are no accurate benchmarks for the initial year. Providers should be provided sufficient time to evaluate their performance and improve prior to publicly reporting their data.

The value of QCDRs lies within their data. However, these proposals distract QCDRs from performing data analytics that would provide meaningful insights for improving quality and efficiency. Trying to understand and comply with constantly changing PQRS requirements, QCDRs are unable to focus their attention on mining their valuable data sets and performing data analytics.

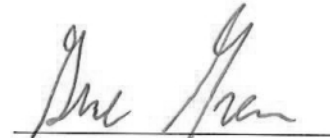
At a time when we are seeking to drive quality and efficiency improvements in health care, we should not create significant barriers to the development, use, and effectiveness of clinical data registries. It is for these reasons that we request the Agency establish a pathway for new and existing clinical data registries to enter and thrive within the QCDR program, which includes establishing clear, stable requirements that reflect the maturity and capabilities of less and more experienced registries. Specifically, in the near term, we request that the Agency maintain the calendar year 2014 QCDR requirements for at least one additional year and propose a new pathway model in the calendar year 2016 rule next year based on clinical data registry stakeholder input.

We appreciate your consideration of the concerns and recommendations outlined in our comments. Should you have any questions concerning this letter please feel free to contact ourselves or J.P. Paluskiewicz with Representative Burgess at James.Paluskiewicz@mail.house.gov or Kristen O'Neill with Representative Green at Kristen.Oneill@mail.house.gov.

Sincerely,



Michael C. Burgess M.D.
Member of Congress




Gene Green
Member of Congress



Marsha Blackburn
Member of Congress



Ami Bera M.D.
Member of Congress



Tom Price M.D.
Member of Congress



Bill Pascrell Jr.
Member of Congress

Dave P. Roe

Phil Roe M.D.
Member of Congress

Paul D. Tonko

Paul Tonko
Member of Congress

Diane Black

Diane Black
Member of Congress



OCT - 7 2015

Administrator
Washington, DC 20201

The Honorable Tom Price ,M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter expressing concerns about the proposed payment for radiation therapy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for radiation therapy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515
Sept 29, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt,

We are writing to express our serious concerns regarding the Centers for Medicare and Medicaid Services (CMS) recent proposal to cut Medicare payments to radiation oncology providers in the physician fee schedule for calendar year 2016. We recognize the valuable role community-based radiation therapy plays in meeting patients' oncology needs and we are concerned that the proposed cuts could further jeopardize patient access to this treatment option.

As you know, radiation oncology is an important cancer treatment option in the battle against cancer, offering patients less invasive care on an outpatient basis that allows many patients to continue living their lives while receiving this treatment. Yet, if CMS' proposed rule is finalized, radiation oncology services would face another three percent overall cut, while freestanding cancer centers would be subject to approximately a six percent payment cut. These cuts could particularly adversely impact patients with prostate and breast cancer because the proposed rule could cut payments for care for these patients by 25 percent and 19 percent, respectively.

The latest proposed cuts follow a disturbing trend of proposed cuts in recent years that has resulted in cumulative payment reductions totaling approximately 20 percent for freestanding cancer centers. We remain not only concerned about the latest proposed cuts to radiation oncology proposed in the 2016 physician fee schedule rule, but also about the repeated proposals in recent years to further cut reimbursement for this care. It is critical that patients have access to quality and timely cancer care in their communities. Therefore, we look forward to working with you to ensure that community-based radiation oncologists have the payment stability necessary to ensure our constituents have access to the radiation oncology care they need, including continued dialogue regarding potential legislative options that achieve these goals.

We strongly urge CMS to reconsider the proposed cuts to radiation therapy in the 2016 physician fee schedule final rule and look forward to continuing to work with you on behalf of our nation's cancer patients. Thanks you in advance for your consideration on these important matters.

Sincerely,



Devin Nunes
Member of Congress



Paul Tonko
Member of Congress

Mark E. Amodei

Rep. Mark E. Amodei

Andy Barr

Rep. Andy Barr

Joe Barton

Rep. Joe Barton

Joyce Beatty

Rep. Joyce Beatty

Dan Benishek

Rep. Dan Benishek

Ami Bera

Rep. Ami Bera, M.D.

Gus M. Bilirakis

Rep. Gus M. Bilirakis

Diane Black

Rep. Diane Black

Marsha Blackburn

Rep. Marsha Blackburn

Charles W. Boustany, Jr.

Rep. Charles W. Boustany, Jr., M.D.

Susan W. Brooks

Rep. Susan W. Brooks

Corrine Brown

Rep. Corrine Brown

Julia Brownley

Rep. Julia Brownley

Vern Buchanan

Rep. Vern Buchanan

Larry Bucshon

Rep. Larry Bucshon, M.D.

Michael C. Burgess

Rep. Michael C. Burgess, M.D.

G.K. Butterfield

Rep. G.K. Butterfield

Bradley Byrne

Rep. Bradley Byrne

Ken Calvert

Rep. Ken Calvert

André Carson


Rep. André Carson

Judy Chu

Rep. Judy Chu

David N. Cicilline

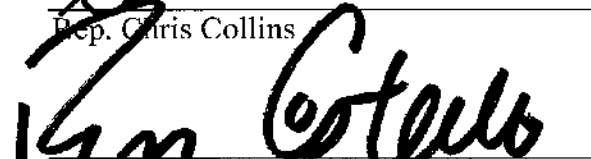
Rep. David N. Cicilline



Rep. Yvette D. Clarke

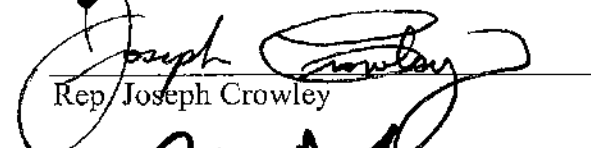

Rep. Steve Cohen


Rep. Chris Collins


Rep. Gerald E. Connolly


Rep. Ryan A. Costello


Rep. Ander Crenshaw


Rep. Joseph Crowley



Rep. Rodney Davis



Rep. Peter A. DeFazio


Rep. Diana DeGette

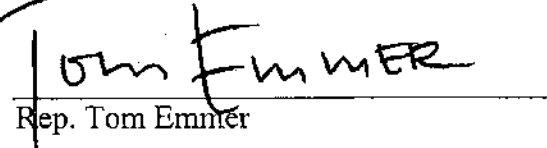

Rep. John K. Delaney


Rep. Suzan K. DelBene


Rep. Scott DesJarlais, M.D.

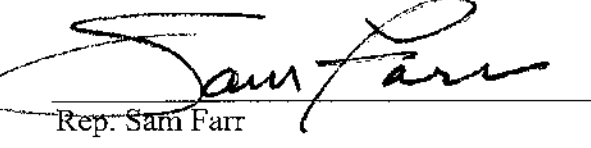

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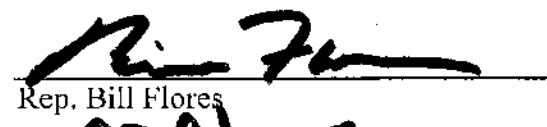

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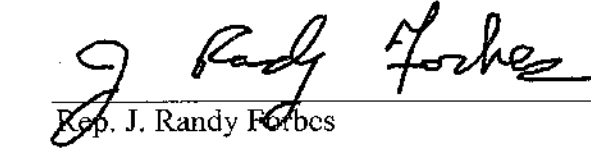

Rep. Tom Emmer


Rep. Eliot L. Engel


Rep. Blake Farenthold


Rep. Sam Farr


Rep. Bill Flores


Rep. J. Randy Forbes

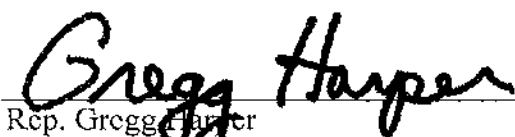

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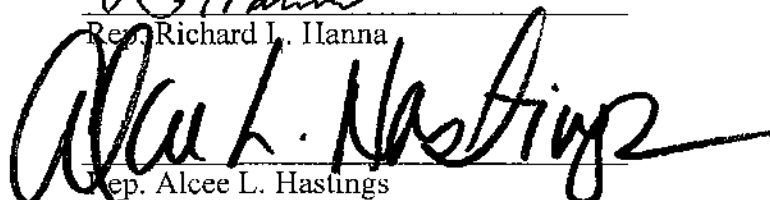

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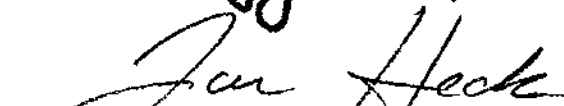

Rep. H. Morgan Griffith


Rep. Brett Guthrie

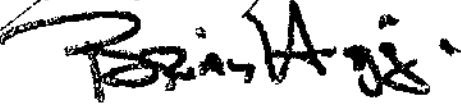

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Rep. Gregg Harper

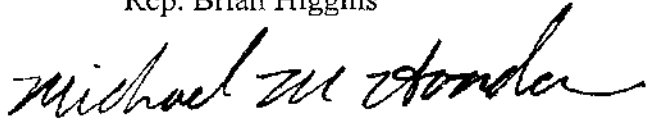

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Rep. Joseph J. Heck, D.O.


Rep. Dean Heck

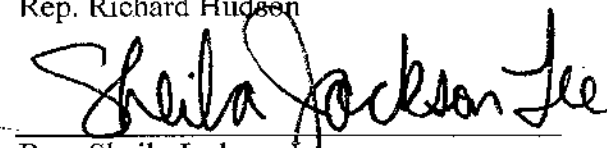

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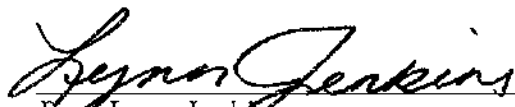

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Rep. Michael M. Honda


Rep. Richard Hudson

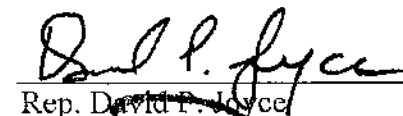

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Rep. Sheila Jackson Lee

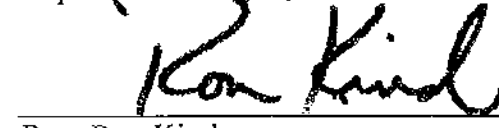

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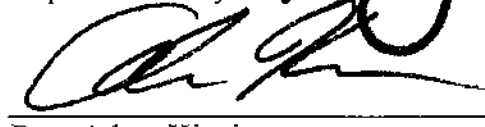

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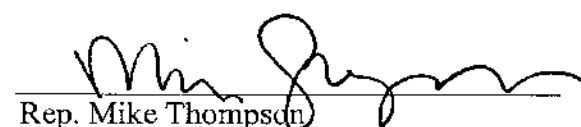

Rep. David W. Jolly


Rep. David P. Joyce


Rep. Mike Kelly


Rep. Ron Kind


Rep. Adam Kinzinger


Rep. Mike Thompson

Ann Kirkpatrick

Rep. Ann Kirkpatrick

Stephen Knight

Rep. Stephen Knight

Leonard Lance

Rep. Leonard Lance

Robert E. Latta

Rep. Robert E. Latta

Frank A. LoBiondo

Rep. Frank A. LoBiondo

David Loebsack

Rep. David Loebsack

Billy Long

Rep. Billy Long

Kenny Marchant

Rep. Kenny Marchant

Michael T. McCaul

Rep. Michael T. McCaul

Betty McCollum

Rep. Betty McCollum

Martha McSally

Rep. Martha McSally

Mark Meadows

Rep. Mark Meadows

Luke Messer

Rep. Luke Messer

Gwen Moore

Rep. Gwen Moore

Patrick Murphy

Rep. Patrick Murphy

Dan Newhouse

Rep. Dan Newhouse

Kristi L. Noem

Rep. Kristi L. Noem

Richard M. Nolan

Rep. Richard M. Nolan

Richard B. Nugent

Rep. Richard B. Nugent

Beto O'Rourke

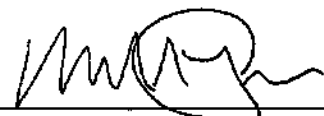
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Pete Olson

Rep. Pete Olson

Erik Paulsen

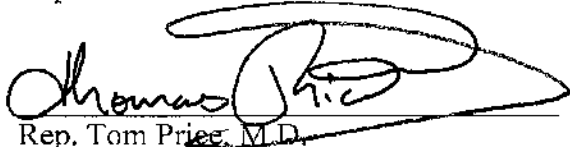
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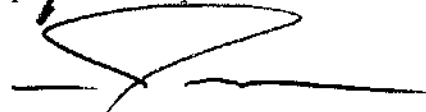
Rep. Mark Pocan



Rep. Mike Pompeo



Rep. Tom Price, M.D.



Rep. Tom Reed



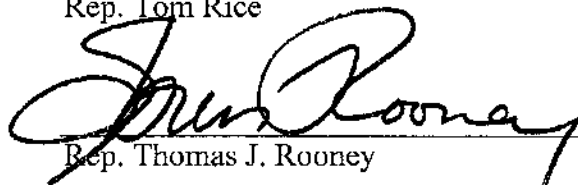
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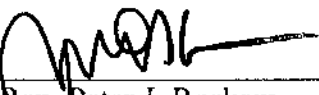
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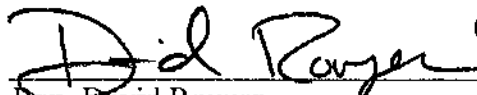
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Rep. Thomas J. Rooney



Rep. Peter J. Roskam



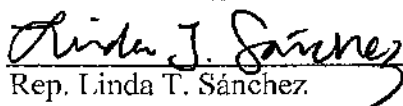
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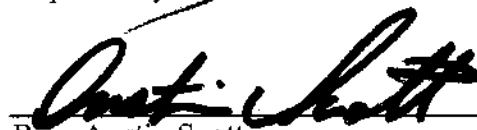
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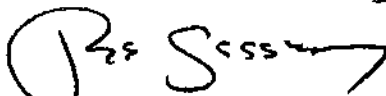
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Rep. Linda T. Sánchez



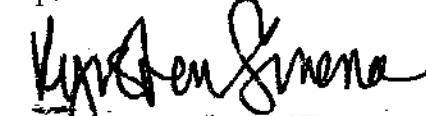
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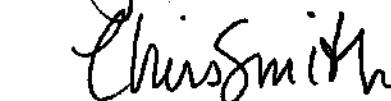
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Rep. John Shimkus



Rep. Krysten Sinema



Rep. Christopher II. Smith



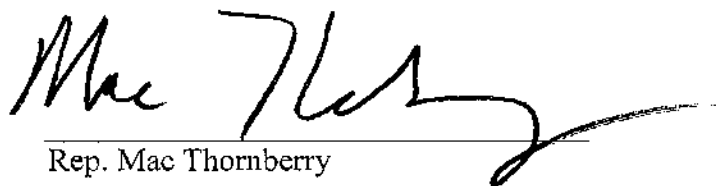
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Rep. Eric Swalwell



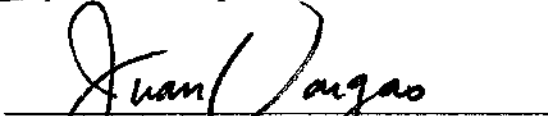
Rep. Scott II. Peters




Rep. Mac Thornberry


Rep. Scott R. Tipton


Rep. Greg Walden



Rep. Juan Vargas



Rep. Timothy J. Walz


Rep. Jackie Walorski



Rep. Brad R. Wenstrup


Rep. Daniel Webster


Rep. Robert J. Wittman


Rep. Ed Whitfield


Rep. Todd C. Young


Rep. Steve Womack



Rep. Gwen Graham

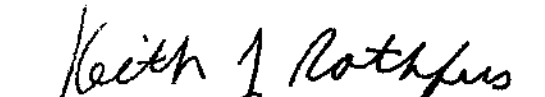

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Rep. Randy Hultgren


Rep. Mike Simpson



Rep. Earl Blumenauer

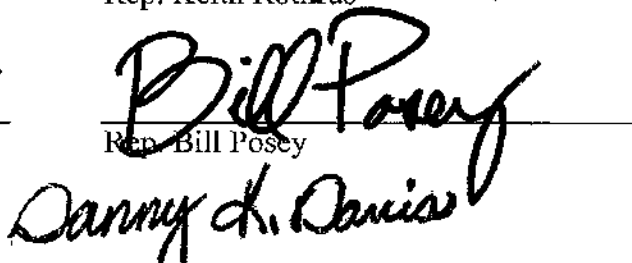

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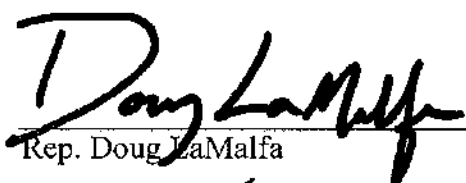

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Rep. Dina Titus


Rep. Bill Posey

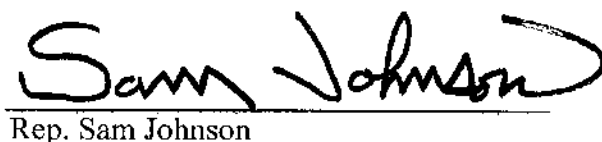

Rep. David G. Valadao


Rep. Danny Davis


Rep. Doug LaMalfa


Rep. French Hill

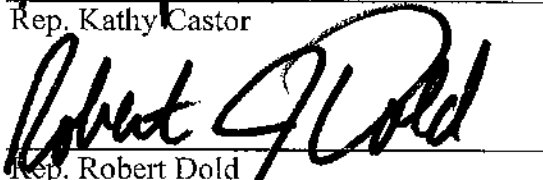

Rep. Derek Klumpp


Rep. Sam Johnson

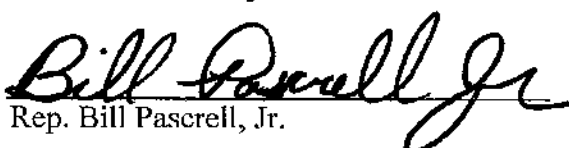

Rep. Ileana Ros-Lehtinen

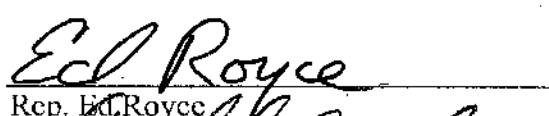

Rep. Kathy Castor


Rep. Jeff Denham

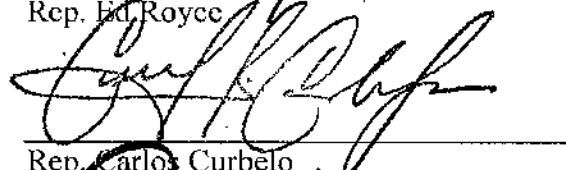

Rep. Robert Dold



Rep. Joseph P. Kennedy, III


Rep. Bill Pascrell, Jr.

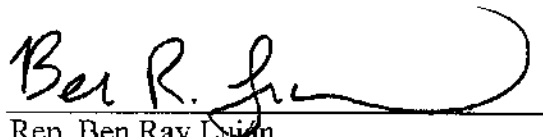

Rep. Ed Royce


Rep. Mike Bishop

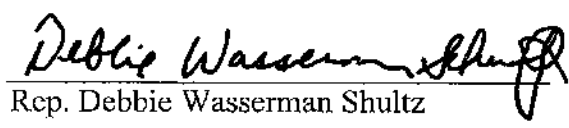

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Rep. Brian Babin


Rep. Duncan Hunter

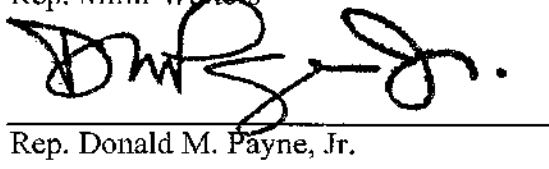

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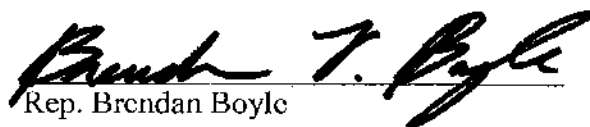

Rep. Blaine Luetkemeyer


Rep. Debbie Wasserman Schultz


Rep. Mimi Walters


Rep. Collin C. Peterson


Rep. Donald M. Payne, Jr.


Rep. Brendan Boyle

Jackie Speier
Rep. Jackie Speier

Peter Welch
Rep. Peter Welch

Raul Ruiz
Rep. Raul Ruiz, M.D.

Jerry McNerney
Rep. Jerry McNerney

Ted Deutch
Rep. Ted Deutch

John Fleming
Rep. John Fleming, M.D.

Jim Langevin
Rep. James R. Langevin

Jeff Miller
Rep. Jeff Miller

Jeb Hensarling
Rep. Jeb Hensarling

Tim Kenney
Rep. Tim Kenney

John Conyers Jr.
Rep. John Conyers



OCT 15 2014

Administrator
Washington, DC 20201

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding our proposal to treat the radiation treatment vault used in radiation treatment services as an indirect practice expense in the calendar year (CY) 2015 Medicare Physician Fee Schedule proposed rule and overall payment for radiation treatment therapy services. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2015 PFS proposed rule was issued on July 3, 2014, and we accepted public comments through September 2, 2014. We will carefully consider all the timely comments we received on this issue before making a final decision in the CY 2015 PFS final rule, which will be issued on or about November 1.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner

REP. DEVIN NUNES
22ND DISTRICT OF CALIFORNIA

**PERMANENT SELECT COMMITTEE
ON INTELLIGENCE**

WAYS AND MEANS
CHAIRMAN, TRADE SUBCOMMITTEE
HEALTH SUBCOMMITTEE



From the desk of
Andrew House
andrew.house@mail.house.gov

**UNITED STATES
HOUSE OF REPRESENTATIVES**

Date: Monday, September 29, 2014

To: Maria Martino,
Director of Congressional Affairs

Fax Number: (202) 690-8168

Number of Pages (Including cover page): 10

Message: Please see attached correspondence addressed to Administrator Tavenner.

Congress of the United States
Washington, DC 20515

September 29, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 337H Humphrey Building
Washington, DC 20201

Dear Administrator Tavenner:

We write to express our opposition to Medicare payment cuts to radiation oncology proposed by the Centers for Medicare and Medicaid Services (CMS) in the physician fee schedule proposed rule for calendar year 2015.

If finalized, the proposed rule would result in a 4% overall cut to radiation oncology – the most among any specialty for CY 2015 – and freestanding centers would suffer an approximately 6% payment cut. Key radiation treatment delivery codes would experience cuts ranging from 5% to more than 15%, worsening payment rate differentials for these services between the hospital outpatient department (HOPD) and freestanding setting, with some HOPD payments becoming approximately 25% higher than freestanding payments in 2015. These payment trends place at risk the availability of community-based therapy which ultimately will drive up costs while reducing the options afforded to our constituents.

It is our understanding that nearly the entire 2015 payment reduction results from a proposed policy change removing the radiation treatment vault as a direct practice expense input, which would limit reimbursement for this costly item that can represent about one-third of the radiation oncology capital expenditure. The rationale for this change is not clear, particularly in light of ample information suggesting the appropriateness of inclusion of the vault as a direct practice expense. The Internal Revenue Service rules, for example, treat radiation treatment vaults as medical equipment -- separately depreciable from the building itself.

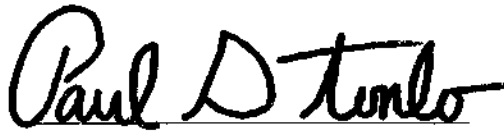
In addition, the radiation oncology community informs us that radiation treatment vaults are unlike anything else in medicine, serving a unique medical need that cannot be repurposed for other use (leases typically require tenants remove vaults before vacating the property). Each treatment vault is distinct from a medical imaging treatment room, as it's designed and constructed to safely house a specific high-energy radiation treatment machine within its space (a change in machine may require extensive modifications of the vault). The vault must comply with specific Nuclear Regulatory Commission licensing regulations to protect patients, clinic staff, and the public from radiation exposure during the delivery of high-energy radiation therapy.

A further factor impacting the appropriateness of this proposal can be found in the ongoing re-review of these same radiation treatment delivery codes which was initiated by CMS in 2013. These new codes, representing approximately two-thirds of radiation oncology care, have gone through the regular process for revising code descriptors and recommended valuation. However, they are not public and are awaiting publication in the Medicare physician fee schedule final rule later this fall. It seems inappropriate to implement such a dramatic policy change to these key codes in the 2015 physician fee schedule when they are still undergoing wholesale changes requested by the agency.

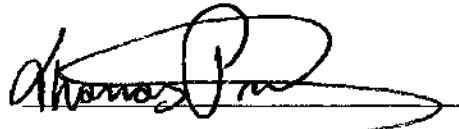
Finally, we would like to take this opportunity to express support for CMS's response to bipartisan, bicameral Congressional calls for transparency and opportunity for stakeholder comment when significant code revisions are proposed. Your plans for improved transparency and stakeholder comment opportunity for new codes beginning in 2016 represents significant progress. However this opportunity is not being provided for the new radiation oncology code set proposed for 2015.

For these reasons, we urge CMS to proceed in a transparent manner that ensures that the public has sufficient time to review and comment on the new codes and any changes to payment rates for radiation oncology services and seriously reconsider the proposed radiation treatment vault policy change.

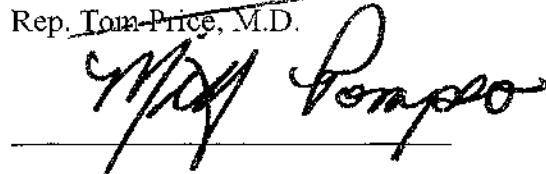
Sincerely,



Rep. Paul Tonko



Rep. Tom Price, M.D.



Rep. Mike Pompeo



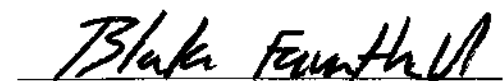
Rep. Bill Posey



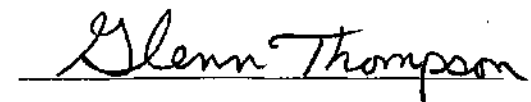
Rep. Devin Nunes



Rep. Patrick Tiberi



Rep. Blake Farenthold



Rep. Glenn 'GT' Thompson

Erik Paulsen

Rep. Erik Paulsen

Jim Renacci

Rep. Jim Renacci

Michael McCaul

Rep. Michael McCaul

Joe Heck

Rep. Joe Heck, D.O.

Leonard Lance

Rep. Leonard Lance

Kathy Castor

Rep. Kathy Castor

Alan Nunnelee

Rep. Alan Nunnelee

Marsha Blackburn

Rep. Marsha Blackburn

Scott Tipton

Rep. Scott Tipton

Tom Rooney

Rep. Tom Rooney

Mark A. Amodei

Rep. Mark Amodei

Mike Thompson

Rep. Mike Thompson

Anna G. Eshoo

Rep. Anna G. Eshoo

Gregg Harper

Rep. Gregg Harper

Brett Guthrie

Rep. Brett Guthrie

Pete Olson

Rep. Pete Olson

Bradley Schneider

Rep. Bradley Schneider

Suzan DelBene

Rep. Suzan DelBene

Aaron Schock

Rep. Aaron Schock

Jeff Miller

Rep. Jeff Miller

Robert J. Wittman

Rep. Robert J. Wittman

Dina Titus

Rep. Dina Titus

Phil Roe

Rep. Phil Roe

David McKinley

Rep. David McKinley

Scott DesJarlais

Rep. Scott DesJarlais, M.D.

John Fleming

Rep. John Fleming, M.D.

Joyce Beatty

Rep. Joyce Beatty

Gerry Connolly

Rep. Gerry Connolly

Renee Ellmers

Rep. Renee Ellmers

Ron DeSantis

Rep. Ron DeSantis

Ander Crenshaw

Rep. Ander Crenshaw

Phil Gingrey

Rep. Phil Gingrey, M.D.

Eric Swalwell

Rep. Eric Swalwell

Paul A. Gosar

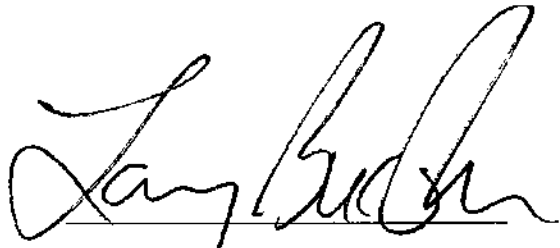
Rep. Paul A. Gosar, D.D.S.

Dan Benishek

Rep. Dan Benishek, M.D.

David G. Valadao

Rep. David G. Valadao



Rep. Larry Bucshon, M.D.



Rep. Todd Young



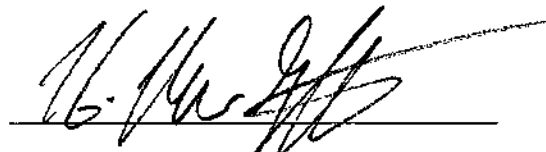
Rep. Ted Deutch



Rep. Lynn Jenkins



Rep. Bill Flores



Rep. H. Morgan Griffith



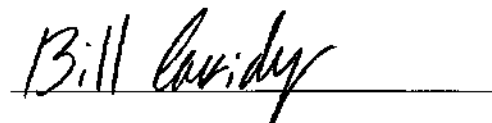
Rep. Kenny Marchant



Rep. Earl Blumenauer



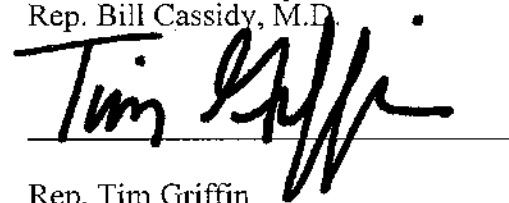
Rep. Steve Womack



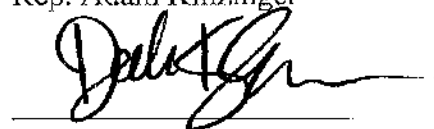
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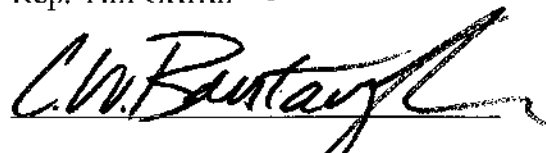
Rep. Adam Kinzinger



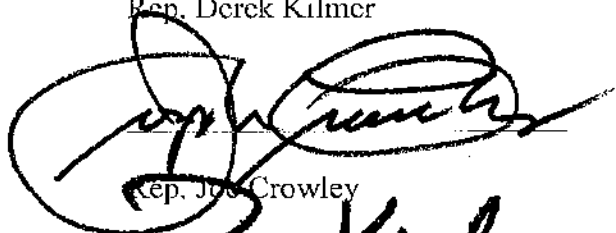
Rep. Tim Griffin



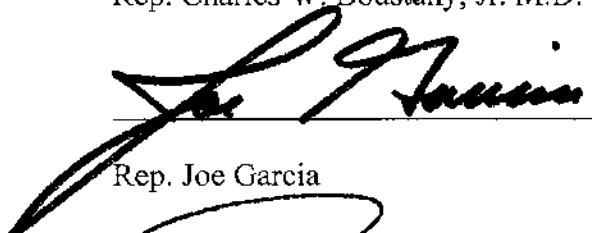
Rep. Derek Kilmer



Rep. Charles W. Boustany, Jr. M.D.



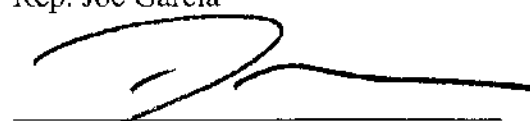
Rep. Joe Crowley



Rep. Joe Garcia



Rep. Ron Kind



Rep. Tom Reed

Susan Brooks

Rep. Susan Brooks

Patrick Murphy

Rep. Patrick E. Murphy

Mike Kelly

Rep. Mike Kelly

Judy Chu

Rep. Judy Chu

Dave Loebsack

Rep. Dave Loebsack

Diane Black

Rep. Diane Black

Billy Long

Rep. Billy Long

Juan Vargas

Rep. Juan Vargas

Chris Gibson

Rep. Chris Gibson

Bill Johnson

Rep. Bill Johnson

Michael M. Honda

Rep. Michael M. Honda

Betsy McCollum

Rep. Betsy McCollum

Richard Nugent

Rep. Richard Nugent

Rodney Davis

Rep. Rodney Davis

Vern Buchanan

Rep. Vern Buchanan

Joe Barton

Rep. Joe Barton

Collin Peterson

Rep. Collin C. Peterson

Mike Rogers

Rep. Mike J. Rogers

Greg Walden

Rep. Greg Walden

Ed Whitfield

Rep. Ed Whitfield

John Barrow

Rep. John Barrow

Henry A. Waxman

Rep. Henry A. Waxman

Jim Matheson

Rep. Jim Matheson

Tom Latham

Rep. Tom Latham

Pete Sessions

Rep. Pete Sessions

Bradley Byrne

Rep. Bradley Byrne

Hank Johnson

Rep. Henry C. "Hank" Johnson

Keith Ellison

Rep. Keith Ellison

James P. Moran

Rep. James P. Moran

Bruce Braley

Rep. Bruce Braley

Lee Terry

Rep. Lee Terry

Bobby L. Rush

Rep. Bobby L. Rush

Ken Calvert

Rep. Ken Calvert

G. K. Butterfield

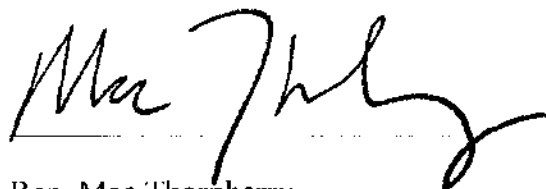
Rep. G. K. Butterfield

Nick Rahall

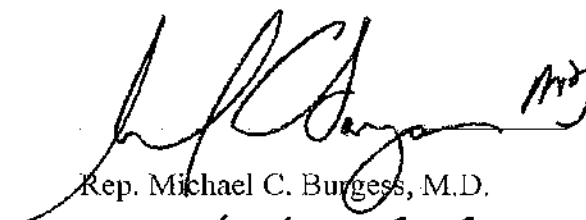
Rep. Nick Rahall

Gus Bilirakis

Rep. Gus Bilirakis



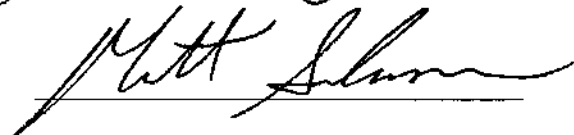
Rep. Mac Thornberry



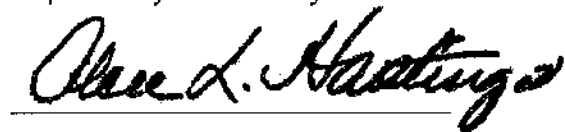
Rep. Michael C. Burgess, M.D.



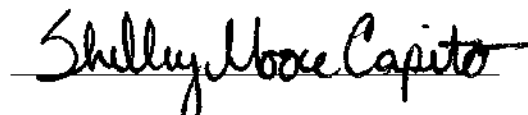
Rep. Carolyn McCarthy



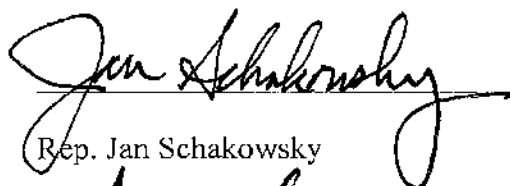
Rep. Matt Salmon



Rep. Alcee L. Hastings




Rep. Shelley Moore Capito



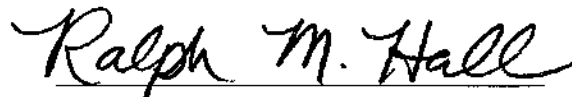
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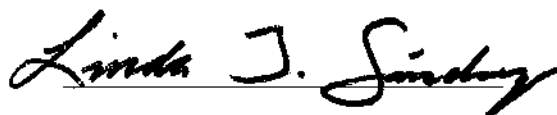
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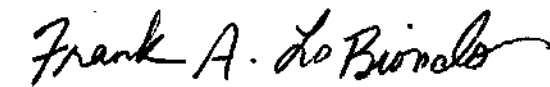
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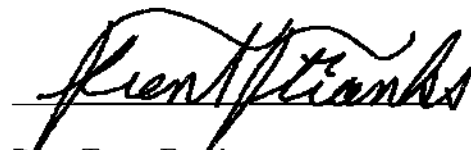
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Rep. Linda Sánchez



Rep. Frank LoBiondo



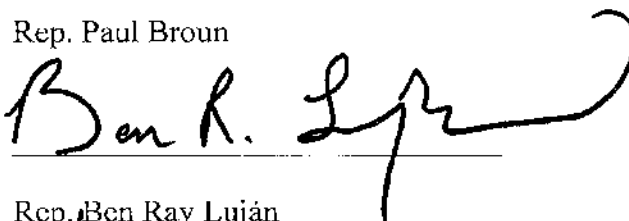
Rep. Trent Franks



Rep. Paul Brown



Rep. Jim Gerlach



Rep. Ben Ray Lujan



Rep. Robert E. Latta



Rep. John Shimkus

Steve Israel

Rep. Steve Israel

Gene Green

Rep. Gene Green

Frank R Wolf

Rep. Frank Wolf

Tom Marino

Rep. Tom Marino

Chris Smith

Rep. Chris Smith

Steven Horsford

Rep. Steven A. Horsford

Rick Nolan

Rep. Rick Nolan

Brian Higgins

Rep. Brian Higgins

Denny Heck

Rep. Denny Heck

Richard Hanna

Rep. Richard Hanna

Austin Scott

Rep. Austin Scott

Cynthia Lummis

Rep. Cynthia Lummis

John B. Larson

Rep. John B. Larson

J. Randy Forbes

Rep. J. Randy Forbes



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Donald M. Payne, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Payne:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Robert A. Brady
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brady:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable James R. Langevin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Langevin:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Erik Paulsen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Paulsen:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator

Washington, DC 20201

The Honorable Eric Swalwell
U.S. House of Representatives
Washington, DC 20515

Dear Representative Swalwell:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Bruce Westerman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Westerman:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Joe Heck, D.O.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Heck:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Frederica S. Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt", is positioned above the typed name.

Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lujan Grisham:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator

Washington, DC 20201

The Honorable Scott R. Tipton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tipton:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Jackie Walorski
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walorski:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Denny Heck
U.S. House of Representatives
Washington, DC 20515

Dear Representative Heck:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable James P. McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Julia Brownley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brownley:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Tim Walz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walz:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Earl Blumenauer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blumenauer:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Steve Womack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Womack:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Scott H. Peters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Pat Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable French Hill
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hill:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Brad Wenstrup
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wenstrup:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Robert J. Dold
U.S. House of Representatives
Washington, DC 20515

Dear Representative Dold:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Alma S. Adams
U.S. House of Representatives
Washington, DC 20515

Dear Representative Adams:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator

Washington, DC 20201

The Honorable David Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Michael F. Doyle
U.S. House of Representatives
Washington, DC 20515

Dear Representative Doyle:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Anna G. Eshoo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Eshoo:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Mark Pocan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pocan:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Brian Babin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Babin:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Suzan K. DelBene
U.S. House of Representatives
Washington, DC 20515

Dear Representative DelBene:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Richard L. Hanna
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanna:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Richard E. Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable John Lewis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lewis:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Phil Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Ted Lieu
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lieu:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Richard Nugent
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nugent:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Rodney Davis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Davis:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Vern Buchanan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Joe Barton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barton:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Corrine Brown
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brown:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Peter A. DeFazio
U.S. House of Representatives
Washington, DC 20515

Dear Representative DeFazio:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare- & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Tom Rooney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rooney:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Ileana Ros-Lehtinen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ros-Lehtinen:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Collin C. Peterson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peterson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Charlie Dent
U.S. House of Representatives
Washington, DC 20515

Dear Representative Dent:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Joe Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Gwen Moore
U.S. House of Representatives
Washington, DC 20515

Dear Representative Moore:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Betty McCollum
U.S. House of Representatives
Washington, DC 20515

Dear Representative McCollum:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Ruben Hinojosa
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hinojosa:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Adam Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Barbara Lee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lee:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Peter Welch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Welch:

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator

Washington, DC 20201

The Honorable G.K. Butterfield
U.S. House of Representatives
Washington, DC 20515

Dear Representative Butterfield:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Rodney P. Frelinghuysen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Frelinghuysen:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Doris Matsui
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Joe Courtney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Courtney:

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Sincerely,

Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Charles Rangel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rangel:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Steve Chabot
U.S. House of Representatives
Washington, DC 20515

Dear Representative Chabot:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Christopher Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Raul Ruiz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ruiz:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Michael E. Capuano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capuano:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

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Andrew M. Slavitt
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

The Honorable Sam Graves
U.S. House of Representatives
Washington, DC 20515

OCT 20 2015

Administrator
Washington, DC 20201

Dear Representative Graves:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Tim Ryan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ryan:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kind:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2016 PFS proposed rule was issued on July 8, 2015, with a 60-day comment period that closed on September 8, 2015. We appreciate your thoughts on our proposed payment for colonoscopy services and we will carefully consider the public comments that we received during the comment period before making final policy decisions. CMS will include the final payment rates for CY 2016 in the final regulation, along with a summary of the comments and our responses. The final regulation is expected to be issued by November 1, 2015.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Mark Takano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Takano:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Tony Cardenas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cardenas:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Reid J. Ribble
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ribble:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Dave Loebsack
U.S. House of Representatives
Washington, DC 20515

Dear Representative Loebsack:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Sean Patrick Maloney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Maloney:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Juan Vargas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Vargas:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Chris Van Hollen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Van Hollen:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Rick Crawford
U.S. House of Representatives
Washington, DC 20515

Dear Representative Crawford:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Michael M. Honda
U.S. House of Representatives
Washington, DC 20515

Dear Representative Honda:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Michael Fitzpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fitzpatrick:

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OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Steve Cohen
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cohen:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Sanford Bishop, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Austin Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Ben Ray Lujan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lujan:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Andre Carson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Brian Higgins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Higgins:

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Paul Tonko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tonko:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



Administrator
Washington, DC 20201

OCT 20 2015

The Honorable Henry C. "Hank" Johnson, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Patrick McHenry
U.S. House of Representatives
Washington, DC 20515

Dear Representative McHenry:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Acting Administrator



OCT 20 2015

Administrator
Washington, DC 20201

The Honorable Patrick Murphy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter expressing concerns about the proposed payment for colonoscopy services in the calendar year (CY) 2016 Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

September 29, 2015

The Honorable Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Mr. Slavitt:

As longstanding proponents of improving colorectal cancer screening rates among Medicare beneficiaries, we are writing in regard to the disconcerting cuts to colonoscopy in Medicare's Physician Fee Schedule proposed rule. Our goal is to reduce barriers to colorectal cancer screening in a manner that is also consistent with the Department of Health and Human Services' (HHS) collaborative goal of 80 percent screening rates for the recommended population by 2018. Colorectal cancer screening is unique in that recommended screening is designed to prevent cancer from occurring in the first place.

Together, HHS and Congress have made tremendous strides in improving screening rates – no other country can boast the positive momentum we have had in saving lives from this disease. According to the American Cancer Society, colorectal cancer incidence rates in the United States have dropped more than 30 percent over the past decade – the large declines over the past decade have been largely attributed to the detection and removal of precancerous polyps as a result of increased colorectal cancer screening.

However, colorectal cancer is still the number two cause of cancer related deaths in the United States and more must be done to increase the screening among Medicare beneficiaries, who are at high risk of colorectal cancer. Medicare beneficiaries account for two-thirds of the more than 133,000 new cases of colorectal cancer each year, according to the U.S. Centers for Disease Control and Prevention (CDC). A recent study published in the *New England Journal of Medicine* concludes that removing precancerous polyps through colonoscopy can not only reduce the risk of colorectal cancer but also reduce the number of deaths from the disease by 53 percent. We strongly agree that we must continue to increase access to and utilization of services such as colorectal cancer screening, which have been historically underutilized.

In light of the Agency's pending proposal to reduce Medicare fee for service reimbursement for colorectal cancer screening and colonoscopy by 10 to 20 percent next year, we feel compelled to express concern that these cuts could jeopardize recent progress and a budding public health success story. Accordingly, we hope you will carefully consider the solicited stakeholder comments on the proposed rule before determining whether cuts of this magnitude are justified by the evidence and are in the interests of Medicare beneficiaries. We remain hopeful that Congress and the Agency can work together to implement consistent policies to further reduce colorectal cancer incidence and mortality.

Together we can help to facilitate this "80 percent by 2018" goal and we look forward to strengthening the Medicare program on behalf of our constituents and Americans nationwide.

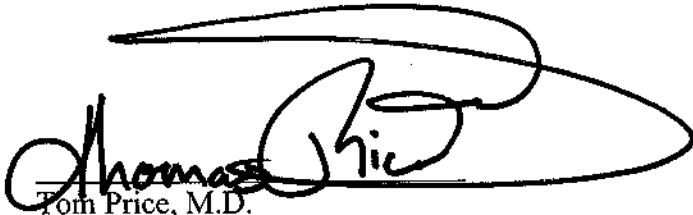
Sincerely,



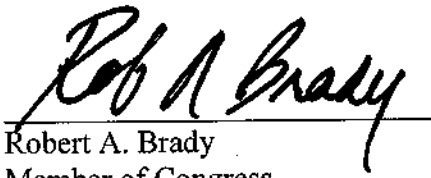
Donald M. Payne, Jr.
Member of Congress



Leonard Lance
Member of Congress



Tom Price, M.D.
Member of Congress



Robert A. Brady
Member of Congress



James R. Langevin
Member of Congress



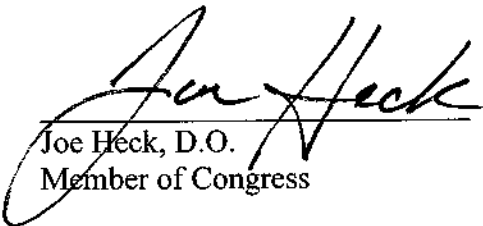
Erik Paulsen
Member of Congress



Eric Swalwell
Member of Congress



Bruce Westerman
Member of Congress



Joe Heck, D.O.
Member of Congress



Frederica S. Wilson
Member of Congress



Michelle Lujan Grisham
Member of Congress



Scott R. Tipton
Member of Congress

Jackie Walorski

Jackie Walorski
Member of Congress

Denny Heck

Denny Heck
Member of Congress

Jim McGovern

James P. McGovern
Member of Congress

Devin Nunes

Devin Nunes
Member of Congress

Julia Brownley

Julia Brownley
Member of Congress

Tim Walz

Tim Walz
Member of Congress

Earl Blumenauer

Earl Blumenauer
Member of Congress

Chris Collins

Chris Collins
Member of Congress

Steve Womack

Steve Womack
Member of Congress

Scott H. Peters

Scott H. Peters
Member of Congress

David P. Joyce

David P. Joyce
Member of Congress

Pat Tiberi


Pat Tiberi
Member of Congress

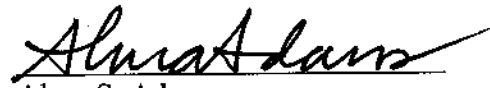
French Hill


French Hill
Member of Congress

Brad Wenstrup


Brad Wenstrup
Member of Congress


Robert J. Dold
Member of Congress



Alma S. Adams
Member of Congress



David Scott
Member of Congress

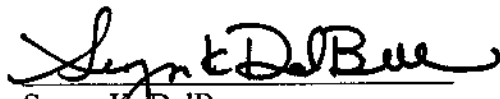

Michael F. Duke
Member of Congress



Anna G. Eshoo
Member of Congress



Gregg Harper
Member of Congress

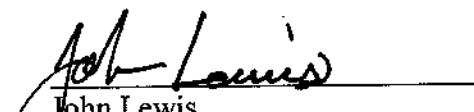

Mark Pocan
Member of Congress



Brian Babin
Member of Congress



Suzan K. DelBene
Member of Congress


Richard L. Hanna
Member of Congress


Richard E. Neal
Member of Congress


John Lewis
Member of Congress


Phil Roe
Member of Congress


Ted Lieu
Member of Congress



Richard Nugent
Member of Congress



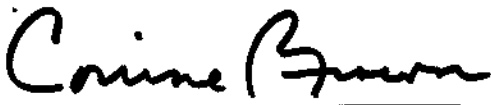
Rodney Davis
Member of Congress



Vern Buchanan
Member of Congress



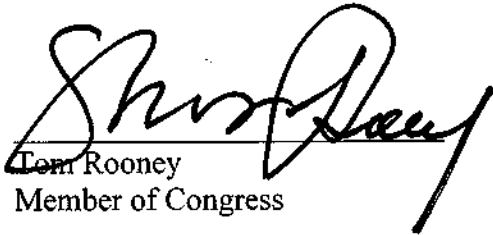
Joe Barton
Member of Congress



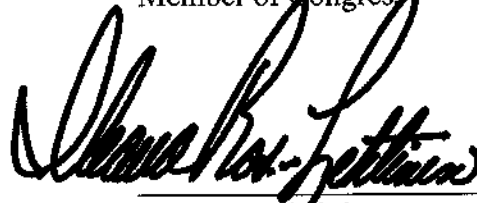
Corrine Brown
Member of Congress



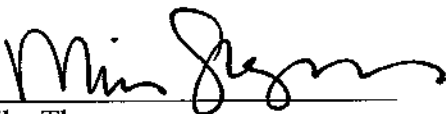
Peter A. DeFazio
Member of Congress



Tom Rooney
Member of Congress



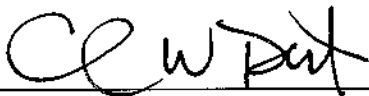
Ileana Ros-Lehtinen
Member of Congress



Mike Thompson
Member of Congress



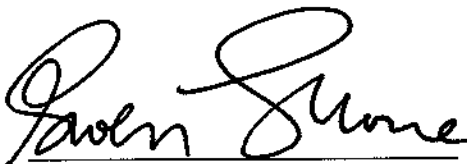
Collin C. Peterson
Member of Congress



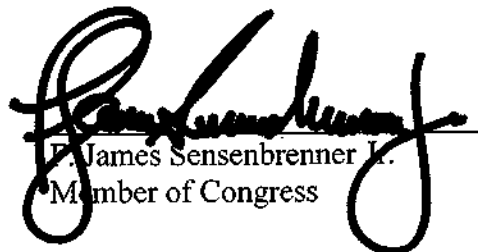
Charlie Dent
Member of Congress



Joe Wilson
Member of Congress



Gwen Moore
Member of Congress



James Sensenbrenner Jr.
Member of Congress

Betty McCollum

Betty McCollum
Member of Congress

Rubén Hinojosa

Rubén Hinojosa
Member of Congress

Adam Smith

Adam Smith
Member of Congress

Marsha Blackburn

Marsha Blackburn
Member of Congress

Barbara Lee

Barbara Lee
Member of Congress

Peter Welch

Peter Welch
Member of Congress

G. K. Butterfield

G. K. Butterfield
Member of Congress

Rodney P. Frelinghuysen

Rodney P. Frelinghuysen
Member of Congress

Doris Matsui

Doris Matsui
Member of Congress

Albio Sires

Albio Sires
Member of Congress

Joe Courtney

Joe Courtney
Member of Congress

Charles Rangel

Charles Rangel
Member of Congress

Steve Chabot


Steve Chabot
Member of Congress

Chris Smith

Christopher Smith
Member of Congress

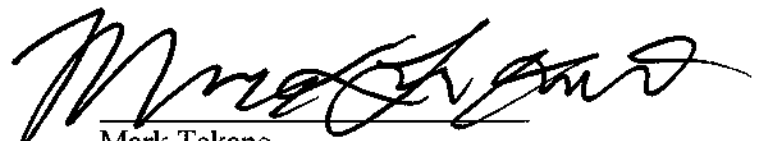

Raul Ruiz
Member of Congress

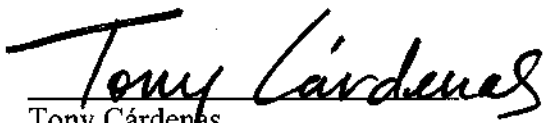

Michael E. Capuano
Member of Congress

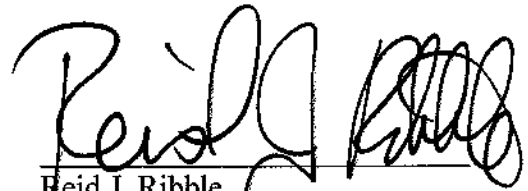

Sam Graves
Member of Congress



Tim Ryan
Member of Congress



Ron Kind
Member of Congress



Mark Takano
Member of Congress



Tony Cárdenas
Member of Congress

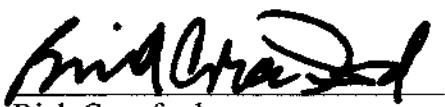

Reid J. Ribble
Member of Congress



Dave Loebsack
Member of Congress


Sean Patrick Maloney
Member of Congress

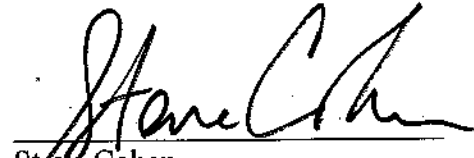

Juan Vargas
Member of Congress

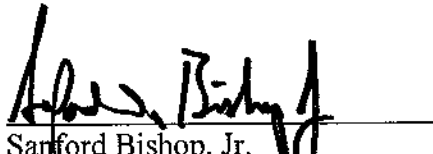

Chris Van Hollen
Member of Congress

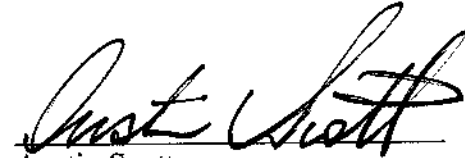

Rick Crawford
Member of Congress



Michael M. Honda
Member of Congress


Michael Fitzpatrick
Member of Congress



Steve Cohen
Member of Congress

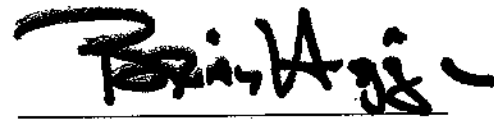

Sanford Bishop, Jr.
Member of Congress



Austin Scott
Member of Congress

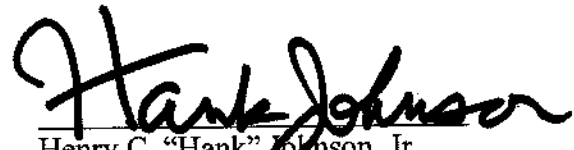

Brett Guthrie
Member of Congress



Ben Ray Lujan
Member of Congress

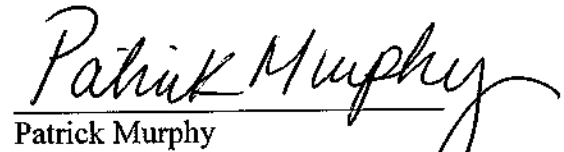

Andre Carson
Member of Congress


Brian Higgins
Member of Congress


Paul Tonko
Member of Congress


Henry C. "Hank" Johnson, Jr.
Member of Congress


Patrick McHenry
Member of Congress


Patrick Murphy
Member of Congress



OCT 28 2014

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the proposed rule addressing that the Centers for Medicare & Medicaid Services (CMS) include athletic trainers as individuals with specialized training for custom fitted orthotics. The CMS greatly appreciates your bringing these concerns to our attention.

The proposed rule clarifying the definition of minimal self-adjustment for orthotics was published in the *Federal Register* on July 11, 2014, as part of the notice of proposed rulemaking: "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The 60-day comment period for this rule ended on September 2, 2014. We received similar timely comments to those you have raised in your letter, which we will carefully consider before making a final decision in the final rule that will be issued on or about November 1.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I have also provided this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end.

Marilyn Tavenner

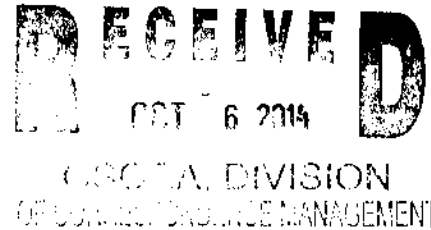
Congress of the United States
Washington, DC 20515

100620144009

DM - 10/21/14

October 3, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244



Dear Administrator Tavenner:

We write to express our concerns about an issue within a proposed rule (79 Federal Register 40207 CMS-1614-P) related to the coverage and payment of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

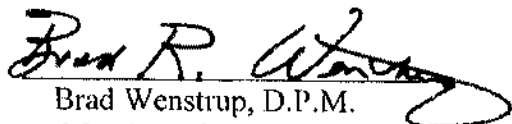
The proposed rule updates the definition of minimal self-adjustment of orthotics by defining those health professionals that have "specialized training" needed to provide custom fitting services. This rule, if it were to go into effect, would exclude athletic trainers from performing services that are an essential part of their education, training, and clinical experience. As health care professionals who collaborate with physicians to provide preventative services, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries, these services are core elements of the role of athletic trainers. We are also concerned that it would reduce patient access to care.

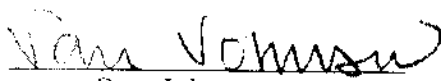
We believe that athletic trainers meet the same requirements and should be included among the health professionals authorized to perform these services, as they are directly related to their clinical expertise, education, training, certification, and licensure.

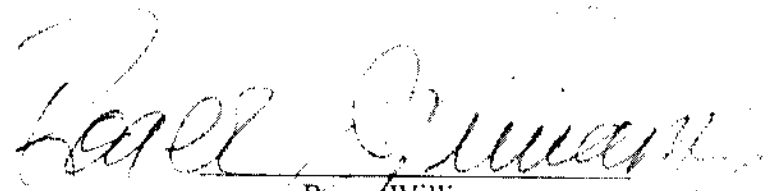
As you may know, certified athletic trainers must earn a degree from an accredited athletic training curriculum at either the baccalaureate or post-baccalaureate level. Athletic trainers receive didactic and clinical education that addresses the continuum of care that would prepare a student to function in a variety of settings. Students engage with patients in a range of activities and conditions to develop sufficient knowledge, skills and clinical abilities, and standards of practice. Athletic trainers are also required to complete continuing education courses that include evidence-based practices.

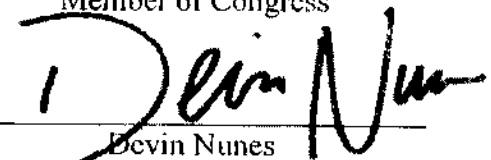
We are very concerned by CMS' actions and urge you to include athletic trainers as health professionals qualified to provide these services.

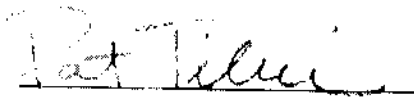
Sincerely,


Brad Wenstrup, D.P.M.
Member of Congress

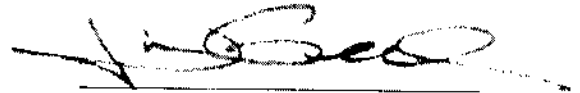

Sam Johnson
Member of Congress


Roger Williams
Member of Congress


Devin Nunes
Member of Congress



Pat Tiberi
Member of Congress



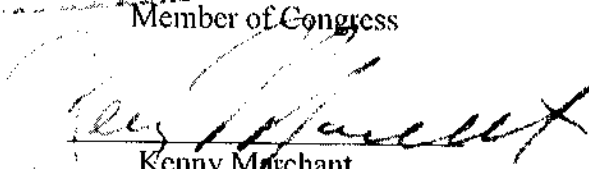
Jim Gerlach
Member of Congress



Tom Price, M.D.
Member of Congress



Aaron Schock
Member of Congress




Kenny Marchant
Member of Congress



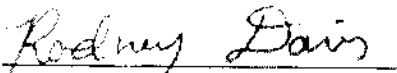
Mike Kelly
Member of Congress



Jim Renacci
Member of Congress



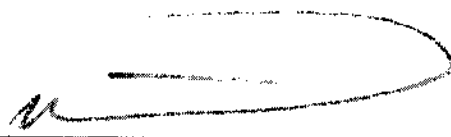
Phil Roe, M.D.
Member of Congress



Rodney Davis
Member of Congress



Bill Johnson
Member of Congress



Scott DesJarlais, M.D.
Member of Congress

Cook, Cynthia E. (CMS/OSORA)

From: Khalid, Zunaira (CMS/OL)
Sent: Monday, October 06, 2014 12:16 PM
To: CMS DCM Correspondence; Dang, Nguyen (CMS/OSORA)
Cc: Keene, Danyail S. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Howell, Cherie A. (CMS/OL); Khalid, Zunaira (CMS/OL); Lehman, Maximillian (CMS/OL); Lewandowski, David S. (CMS/OL); Martino, Maria (CMS/OL); Phillips, Josh A. (CMS/OL); Saklas, Ariadne (CMS/OL)
Subject: FW: Rep. Brad Wenstrup letter to Administrator Tavenner
Attachments: CMS DME Bracing letter_final signed.pdf
Importance: High

Please control.

From: Collins, Lisa [<mailto:Lisa.Collins@mail.house.gov>]
Sent: Friday, October 03, 2014 4:57 PM
To: Khalid, Zunaira (CMS/OL)
Subject: Rep. Brad Wenstrup letter to Administrator Tavenner

Hi Zunaira,

My boss is sending the attached letter to Administrator Tavenner; please find an electronic version attached.

Thank you,
Lisa

Lisa Collins
Legislative Director
Rep. Brad Wenstrup (OH-02)
1223 Longworth House Office Building
202-225-3164



OCT 17 2008

Administrator
Washington, DC 20201

The Honorable Tom Price
House of Representatives
Washington, DC 20515

Dear Mr. Price:

Thank you for your letter regarding ambulatory surgical center payments.

The proposed rule CMS-1404-P, "Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for CY 2009," was published in the *Federal Register* on July 18, 2008, with a comment period that ended on September 2.

One of the purposes of the proposed rule was to solicit comments from interested parties. We have received many responses, including some that express concerns similar to yours. All comments received during the comment period will be considered before the final rule is published. A summary of the comments and our responses will also be included with the final regulation.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry Weems".

Kerry Weems
Acting Administrator

Congress of the United States
Washington, DC 20515

Cmm
100820084063
DUE DATE - 10-23-08

October 1, 2008

Mr. Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Weems:

We are writing to express our strong concerns about the proposed CMS rule for ambulatory surgery center (ASC) payments in 2009. As recently as five years ago, ASCs were paid 86.5 percent of hospital outpatient departments (HOPDs), on average. If the proposed rule were adopted, Medicare would pay ASCs only 59 percent of what hospitals receive for the same procedures. As a result, many procedures will no longer be viable in the ASC setting, meaning that costs will go up for the Medicare program and its beneficiaries as these procedures migrate to the hospital setting.

Since ASCs and HOPDs provide identical services, we believe CMS should adopt policies that maintain the alignment between ASC and HOPD payments. In particular:

- CMS should apply outpatient prospective payment system (OPPS) relative weights directly to the ASC payment rates instead of applying a secondary "rescaling" of the ASC rates.
- CMS should apply the same market basket updates to ASCs as HOPDs.

The primary cause of the additional payment cuts for 2009 is CMS's failure to use the same relative weights for surgical procedures in both the OPPS and ASC system. CMS proposes to break the link between the OPPS and ASC payment system and remove the effect of rising costs on the relative weights in the ASC, resulting in a further divergence between HOPD and ASC payments for identical procedures. As a consequence, ASCs will be penalized for providing a greater volume of procedures to Medicare beneficiaries at a lower cost than hospitals.

We do not believe this policy is in the best interest of the Medicare program or its beneficiaries. At a time when Medicare is struggling to contain overall costs, it does not make sense to penalize providers who are able to perform services more efficiently. Nothing in the statute requires such a budget neutrality adjustment. We are also concerned that CMS lacks adequate data to make an accurate secondary re-scaling adjustment, as the data now being used predates the payment system established last year and the 40% of procedures new to the ASC list. Furthermore, severing the link between the OPPS and the ASC payment system undermines CMS's broader efforts to improve the transparency of pricing systems for Medicare beneficiaries.

Finally, we believe the hospital market basket unquestionably is a more appropriate basis for annual ASC updates than the CPI-U, a measure that is not used to update any other Medicare prospective payment system. ASCs face inflationary pressures similar to those confronted by hospitals. Intense competition for nurses, rapidly rising medical device costs, and a growing need to adapt new health information technology contribute to inflation across a variety of health care settings. CMS uses the hospital market basket, which takes these costs into account, as the inflation update for the OPPS system. Use of CPI-U is not only inappropriate, it will also result in a growing divergence of payments over time between ASCs and HOPD for providing the identical services.

As you finalize the 2009 payment rule for ASCs, we urge you to modify these elements of the proposed rule to ensure that ASCs continue to be a high-quality, cost-effective option for Medicare beneficiaries. Thank you for your consideration of our concerns.

Sincerely,



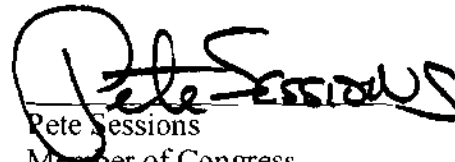
Kendrick B. Meek
Member of Congress



Wally Hergert
Member of Congress



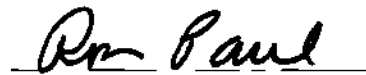
Bruce Braley
Member of Congress



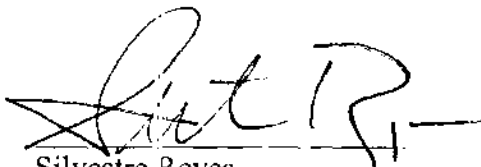
Pete Sessions
Member of Congress



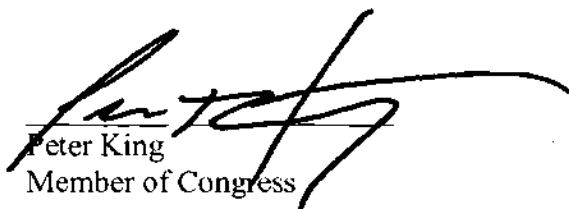
Ron Klein
Member of Congress



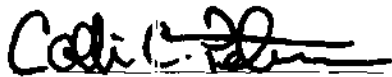
Ron Paul
Member of Congress



Silvestre Reyes
Member of Congress



Peter King
Member of Congress



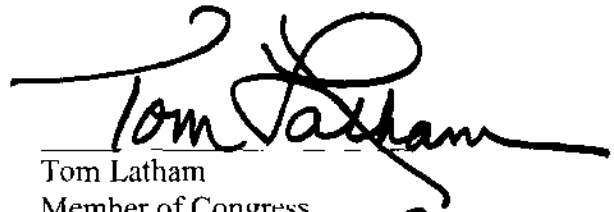
Collin Peterson
Member of Congress



Tom Price
Member of Congress



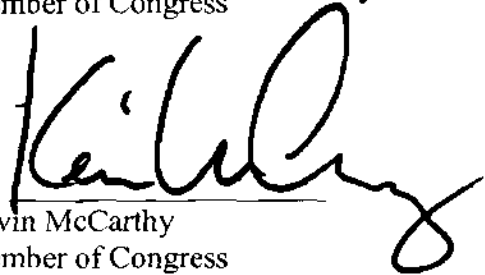
Rick Larsen
Member of Congress



Tom Latham
Member of Congress



Leonard L. Boswell
Member of Congress



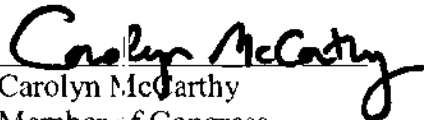
Kevin McCarthy
Member of Congress



Dave Loebsack
Member of Congress



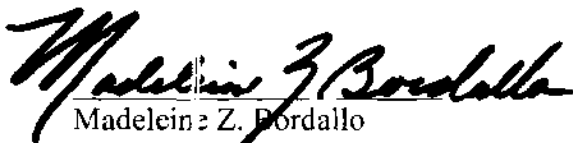
Marsha Blackburn
Member of Congress



Carolyn McCarthy
Member of Congress



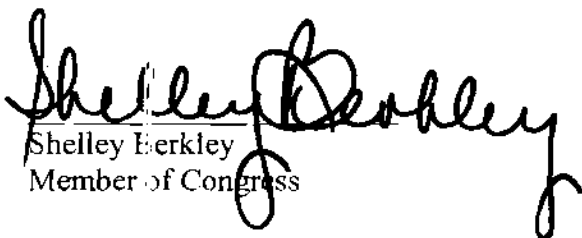
Phil English
Member of Congress



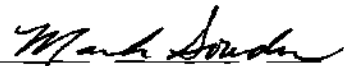
Madeleine Z. Bordallo
Member of Congress



Steve King
Member of Congress



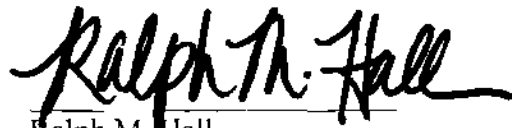
Shelley Berkley
Member of Congress



Mark Souder
Member of Congress



Corrine Brown
Member of Congress



Ralph M. Hall
Member of Congress



Solomon P. Ortiz
Member of Congress



Sam Johnson
Member of Congress



Bill Pascrell, Jr.
Member of Congress

Oct. 15, 2008 2:20PM

No. 0711 RECEIVED P. 2
Oct 16, 2008 15:20:41 WS# 22
OSNUM: 101620081045
OFFICE OF THE SECRETARY
CORRESPONDENCE
CONTROL CENTER

Congress of the United States
Washington, DC 20515

October 7, 2008

The Honorable Mike Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

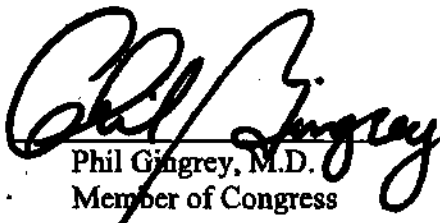
We write to express our concern with the recent recommendation by the U.S. Advisory Committee on Immunization Practices (ACIP) to include the human papillomavirus (HPV) vaccine among the required vaccines for any immigrant seeking adjustment of status to permanent resident. Accordingly, we respectfully ask that the HPV vaccine be removed from this list of required vaccines.

First, while we fully recognize the need to combat the spread of communicable diseases through vaccines, HPV is fundamentally different from the other diseases for which ACIP recommends vaccines. Unlike influenza or hepatitis, HPV cannot be contracted through casual contact, but rather only through sexual contact. Under the ACIP age guidelines, however, girls as young as 11 could be required to receive an HPV vaccine.

Additionally, Judicial Watch, a Washington-based public interest group, recently reported that there have been close to 9,000 health complaints linked to Gardasil – the FDA-approved HPV vaccine. These complaints have surfaced because recipients of the vaccine have experienced symptoms ranging from massive wart outbreaks to paralysis, and – in 18 cases – death. Given the potential risks and possible adverse reactions, women and parents (in the case of minors) should be able to make an informed decision as to whether or not this vaccine should be administered.

In light of these concerns, we firmly believe it is inappropriate to make HPV vaccination mandatory for any young girl or woman – whether a citizen or an immigrant. The decision to receive this vaccine ultimately should rest with the patient or guardian. Again, we respectfully request that you consider reversing this decision by the ACIP.

Sincerely,


Phil Gingrey, M.D.
Member of Congress


Joseph R. Pitts
Member of Congress

*** RECEIVED ***
Oct 16, 2008 15:20:41 WS# 22
OSNUM: 101620081045
OFFICE OF THE SECRETARY
CORRESPONDENCE
CONTROL CENTER

Rodney Alexander
Rodney Alexander
Member of Congress

Rescoe Bartlett
Rescoe Bartlett
Member of Congress

Michele Bachmann
Michele Bachmann
Member of Congress

Marsha Blackburn
Marsha Blackburn
Member of Congress

Paul Broun
Paul Broun, M.D.
Member of Congress

Dan Burton
Dan Burton
Member of Congress

Nathan Deal
Nathan Deal
Member of Congress

Jo Ann Emerson
Jo Ann Emerson
Member of Congress

Mary Fallin
Mary Fallin
Member of Congress

Jeff Fortenberry
Jeff Fortenberry
Member of Congress

Pete Hoekstra
Pete Hoekstra
Member of Congress

Jim Jordan
Jim Jordan
Member of Congress

Jack Kingston
Jack Kingston
Member of Congress

Doug Lamborn
Doug Lamborn
Member of Congress



Michael T. McCaul
Member of Congress



Marilyn Musgrave
Member of Congress



Ron Paul, M.D.
Member of Congress



Tom Price, M.D.
Member of Congress



Bill Sali
Member of Congress



Chris Smith
Member of Congress



John Sullivan
Member of Congress



Lynn Westmorland
Member of Congress



CONGRESSMAN PHIL GINGREY

WASHINGTON OFFICE

119 CANNON HOUSE OFFICE BUILDING

WASHINGTON, D.C. 20515

(202) 225-2931 PHONE

(202) 225-2944 FAX

FAX COVER SHEET

TO: Secretary Mike Leavitt
Department of Health & Human Services

DATE: 10 / 15 / 2008

TIME: 2 : 20 am pm

FAX NUMBER: (202) 690-7380

TOTAL PAGES (INCLUDING COVER):

4

FROM:

Congressman Phil Gingrey

Catherine Morvis

Chris Jackson

Michael Calvo

Andrew Watson

Sean Dalton

David Sours

Joshua Waller

Julia Taff

Jeffrey Bloom



NOTES/COMMENTS:

Please see attached letter.



NOV 22 2013

Administrator
Washington, DC 20201

The Honorable Tom Price ,MD
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding our proposal to limit the non-facility practice expense payment for individual codes so that the total non-facility payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting in the Calendar Year (CY) 2014 Medicare Physician Fee Schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

The CY 2014 PFS proposed rule was issued on July 8, 2013, with a 60-day comment period that closed on September 6, 2013. We appreciate your concerns and note that we received several public comments on the proposed rule raising similar issues. We are carefully considering the issues raised in this letter in addition to other public comments we received on proposed changes during the comment period and will include the final policies in the CY 2014 PFS final rule with comment period. We anticipate issuing a final rule soon.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner

Congress of the United States
Washington, DC 20515

October 17, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 337H Humphrey Building
Washington, DC 20201

RECEIVED

OCT 24 2013

OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Dear Administrator Tavenner:

We write to urge CMS to withdraw its proposal in the Calendar Year (CY) 2014 Medicare Physician Fee Schedule (PFS) Proposed Rule. This rule would place a cap on non-facility (office-based) practice expense (PE) payment for 211 physician services at either hospital outpatient prospective payment system (OPPS) or ambulatory surgical center (ASC) rates because the agency believes these payments are potentially "misvalued". The proposal will reduce payments for many services by 50 percent or more, potentially making them unavailable in physicians' offices, thus denying patients access to services in a more convenient and less fragmented setting.

Under CMS' proposal, services provided less than five percent of the time in the hospital outpatient setting are supposedly exempt from the cap. Many of these services, however, are being capped at the OPPS rate even though they are never or rarely performed in that setting. Many services being capped at the OPPS rate have their technical and professional components separated and may typically be performed in completely different sites of service. Capping the entire service without consideration of the efficiencies achieved through differing sites of service for the professional, technical, and global components is shortsighted. In addition, it is unclear why CMS chose to apply the ASC rate as a cap to many of the 211 listed codes, even if the services were provided less than five percent of the time in an ASC. In fact, only eight of the 112 codes that are being tied to the ASC payment rate are actually provided in an ASC at least five percent of the time.

We also believe the proposal's underlying premise is flawed. CMS has ignored fundamental differences in Medicare methodologies between the statutorily-required, resource-based relative value scale (RBRVS) that is the basis for the PFS and the ambulatory payment classifications (APCs) used for OPPS and ASC rates. These differences render service-by-service comparisons inappropriate and inaccurate. APCs are a bundled payment system that average low and high margin hospital services within single APCs. In contrast, the RBRVS captures the relative resource used for each individual service. In addition, we believe this proposal violates a Medicare statutory requirement that PE Relative Value Units (RVUs) be resource-based for the particular practice setting. Finally, CMS is proposing to use the 2013 OPPS/ASC payment rates, which ignores corrections and adjustments by CMS for OPPS and ASC rates in 2014.

For the majority of the codes with proposed reductions, the direct expenses alone (clinical labor, supplies, and equipment) exceed the proposed payment cap. This will result in physicians' offices being unable to cover their direct costs to provide these services. Along with our concerns about limiting patient access to care, we are also concerned that support staff employed by office-based practices, which are small businesses, may have to be eliminated as a direct result of these proposed drastic PE cuts.

Based on the concerns outlined above, we urge CMS to withdraw this proposal prior to the publication of the CY 2014 Medicare PFS Final Rule in early November.

If you or your staff has any questions, please contact John Martin with Congressman Roe at (202) 225-6356 or john.martin@mail.house.gov.

Sincerely,

David P Roe

Renee Hillman

Paul Brown

Larry Bushon

CW Bonatony

Bill Cassidy

Joe Heck

Paul Lujan

Phil Gingrey

(TN-04)

John D. Dingens (MD)

(MD-01)

Fred R. Wastny
Fred

Thomas O'Rourke

Don Brinkley

John Fleming



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Tim Murphy, Ph.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

As noted in your letter, ICD-10 is significantly different from the current and outdated ICD-9 medical code set. The ICD-9 code set is more than 30 years old, and cannot accurately reflect current medical technologies. The more descriptive nature of ICD-10 better reflects the level of detail being entered by the provider into the patient's medical record. The robust data of the ICD-10 codes will result in improvements in quality measurements, public health, research, organizational monitoring and performance, as well as more accurate payments.

Further, this effort is central to other important initiatives, including implementation of new health care delivery models that require new types of reimbursement to providers; adoption of electronic health records; identification of fraud and abuse in the Medicare, Medicaid, and Children's Health Insurance Programs; and improved public health reporting to allow for a quick response to public health outbreaks.

In response to more than 3,000 industry comments received on our notice of proposed rulemaking published in the *Federal Register* in August 2008, the Department of Health and Human Services (HHS) pushed the ICD-10 compliance date back an additional two years, from October 1, 2011, to October 1, 2013, to provide industry with sufficient time to comply. We also relied heavily on the recommendation of the National Committee on Vital and Health Statistics (NCVHS), a Federal Advisory Committee Act committee charged with making recommendations to the Secretary of HHS regarding the adoption of standards and code sets. The NCVHS recommendation, after extensive industry testimony and review of multiple studies, was that the ICD-10 medical code set was the most appropriate system, and should be adopted.

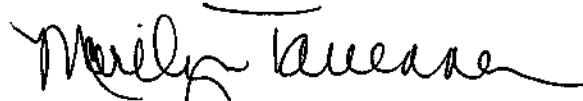
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Page 2 – The Honorable Tim Murphy, Ph.D.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the health care industry. I will also provide this response to the cosigners of your letter.

Sincerely,

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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Phil Roe, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

As noted in your letter, ICD-10 is significantly different from the current and outdated ICD-9 medical code set. The ICD-9 code set is more than 30 years old, and cannot accurately reflect current medical technologies. The more descriptive nature of ICD-10 better reflects the level of detail being entered by the provider into the patient's medical record. The robust data of the ICD-10 codes will result in improvements in quality measurements, public health, research, organizational monitoring and performance, as well as more accurate payments.

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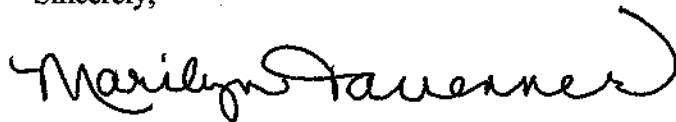
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Sincerely,

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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

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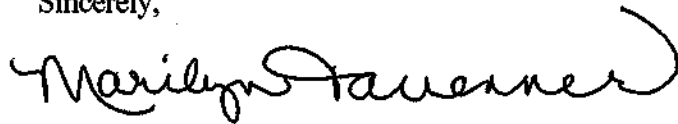
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Sincerely,

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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Diane Black, R.N.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

As noted in your letter, ICD-10 is significantly different from the current and outdated ICD-9 medical code set. The ICD-9 code set is more than 30 years old, and cannot accurately reflect current medical technologies. The more descriptive nature of ICD-10 better reflects the level of detail being entered by the provider into the patient's medical record. The robust data of the ICD-10 codes will result in improvements in quality measurements, public health, research, organizational monitoring and performance, as well as more accurate payments.

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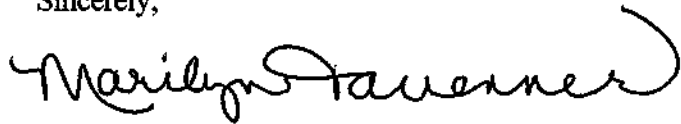
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Sincerely,

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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Michael Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

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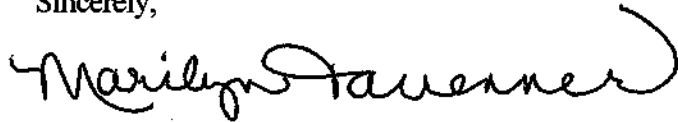
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Sincerely,

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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Ron Paul, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Paul:

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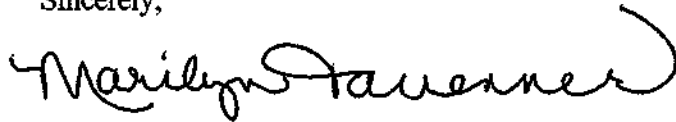
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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Mike Simpson, D.D.S.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Simpson:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

As noted in your letter, ICD-10 is significantly different from the current and outdated ICD-9 medical code set. The ICD-9 code set is more than 30 years old, and cannot accurately reflect current medical technologies. The more descriptive nature of ICD-10 better reflects the level of detail being entered by the provider into the patient's medical record. The robust data of the ICD-10 codes will result in improvements in quality measurements, public health, research, organizational monitoring and performance, as well as more accurate payments.

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In response to more than 3,000 industry comments received on our notice of proposed rulemaking published in the *Federal Register* in August 2008, the Department of Health and Human Services (HHS) pushed the ICD-10 compliance date back an additional two years, from October 1, 2011, to October 1, 2013, to provide industry with sufficient time to comply. We also relied heavily on the recommendation of the National Committee on Vital and Health Statistics (NCVHS), a Federal Advisory Committee Act committee charged with making recommendations to the Secretary of HHS regarding the adoption of standards and code sets. The NCVHS recommendation, after extensive industry testimony and review of multiple studies, was that the ICD-10 medical code set was the most appropriate system, and should be adopted.

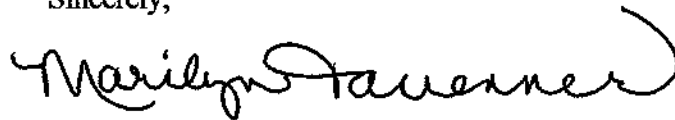
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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the health care industry. I will also provide this response to the cosigners of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable John Fleming, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleming:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

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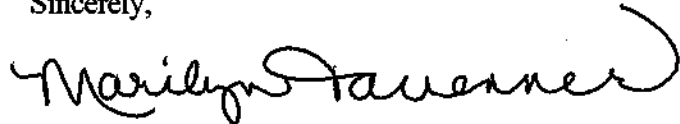
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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Andy Harris, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harris:

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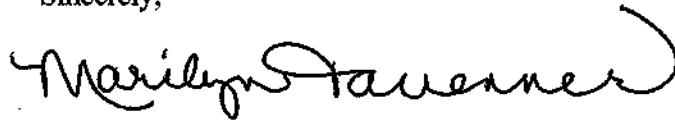
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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

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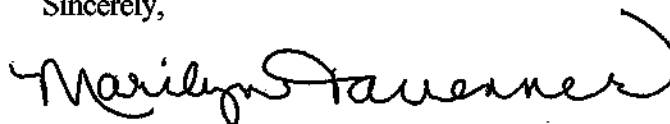
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Marilyn Tavenner
Acting Administrator



DEC 23 2011

Administrator
Washington, DC 20201

The Honorable Phil Gingrey, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

Thank you for your letter expressing concerns regarding implementation of the ICD-10 medical code sets scheduled for October 1, 2013. I very much appreciate your bringing these concerns to our attention.

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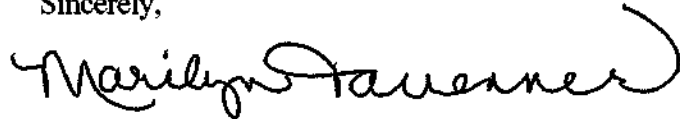
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Marilyn Tavenner
Acting Administrator

Cm
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DUE - 11-14-11

Congress of the United States
Washington, DC 20515

October 27, 2011

Dr. Donald Berwick
Administrator
Centers for Medicaid and Medicare Services
7500 Security Boulevard
Baltimore, MD 21244

RECEIVED

OCT 28 2011

OSORA, DIVISION OF
CORRESPONDENCE MANAGEMENT

Dear Administrator Berwick:

We write today with our concerns over dramatic changes in medical billing codes that many physicians believe will have no discernable benefit to health status or outcomes, and will only serve to add cost burdens and significant challenges for providers.

Currently, providers must sift through 18,000 ICD-9 diagnosis codes in order to bill insurers. New requirements by the Centers for Medicare and Medicaid Services (CMS), in the form of implementing the use of ICD-10 diagnosis codes, will increase the number of billing codes by nearly eight times, providing the federal government with intricate details about a patient's illness or injury, consuming an extensive amount of time for providers (an incredibly scarce resource), and accelerating expanding healthcare costs.

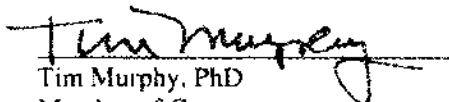
Many of the changes are unnecessary and overly burdensome. For example, ICD-10 code W22.02xS would generate the proper billing for a patient who pathologically walks into lampposts; and ICD-10 code Y92.253 is the specific code for injuries and illnesses that take place at an opera house.


These types of mandates do not help healthcare providers treat patients better or with greater safety, but will certainly raise the cost of providing that care. In order to comply with the mandate, physicians will need to make expensive updates (or replacements) to their office systems, train themselves and their staff to use the new coding system, and integrate the new system into their routine office processes – all while trying avoid significant productivity and revenue losses during the implementation. A small medical practice of five physicians will be forced to spend approximately \$166,000 over the first three years to implement the ICD-10 codes. Furthermore, the October 1, 2013 compliance deadline is far too soon for providers to undertake implementing these mountainous reforms into their daily practice.

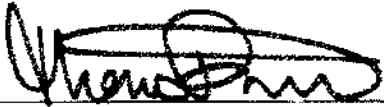
With new mandates from the Patient Protection and Affordable Care Act (PL 111-148), providers are already facing costly requirements that will limit quality care for their patients. Adding an extra layer of bureaucracy will only serve to undermine the doctor and patient relationship.

Moreover, the World Health Organization, the creators of the new billing guidelines, has a history of implementing methodologies contrary to the standards of care practiced in the United States. As providers undertake the transition to ICD-10, we urge you to reexamine the ICD-10 billing codes to create a system that takes into account the concerns of the physician community.

Sincerely,


Tim Murphy, PhD
Member of Congress

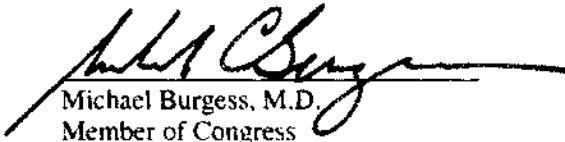

Phil Roe, M.D.
Member of Congress



Tom Price, M.D.
Member of Congress



Diane Black, R.N.
Member of Congress



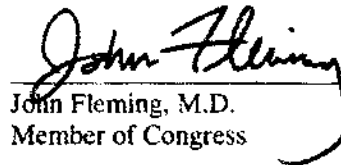
Michael Burgess, M.D.
Member of Congress



Ron Paul, M.D.
Member of Congress



Mike Simpson, D.D.S.
Member of Congress



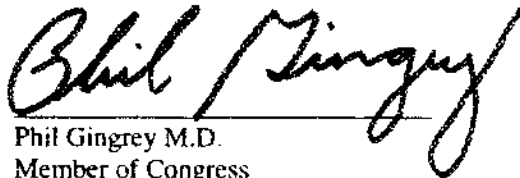
John Fleming, M.D.
Member of Congress



Andy Harris, M.D.
Member of Congress



Larry Buschon, M.D.
Member of Congress



Phil Gingrey M.D.
Member of Congress

Young, Sheila L. (CMS/OSORA)

From: Nixon, Karen E. (CMS/OSORA)
Sent: Friday, October 28, 2011 1:07 PM
To: Young, Sheila L. (CMS/OSORA)
Subject: FW: Ltr from Rep. Murphy on ICD-10
Attachments: Ltr to Berwick on Medical Billing Codes 10.27.201.pdf

Please control. Thanks

From: Murray, Heinz (CMS/OL)
Sent: Friday, October 28, 2011 11:21 AM
To: Nixon, Karen E. (CMS/OSORA); Bailey, Glenda G. (CMS/OSORA)
Cc: Lewandowski, David S. (CMS/OL)
Subject: FW: Ltr from Rep. Murphy on ICD-10

Please control the attached file. Thank you.

R, Heinz

From: Lewandowski, David S. (CMS/OL)
Sent: Friday, October 28, 2011 11:18 AM
To: Murray, Heinz (CMS/OL)
Subject: FW: Ltr from Rep. Murphy on ICD-10

Heinz, please have the attached controlled. Thanks.

From: Grantz, Brad [<mailto:Brad.Grantz@mail.house.gov>]
Sent: Friday, October 28, 2011 11:16 AM
To: Lewandowski, David S. (CMS/OL)
Cc: Holt, Chris
Subject: Ltr from Rep. Murphy on ICD-10

Hi David –

Please see the attached letter from Rep. Murphy and members of the GOP Doctors Caucus with concerns over the ICD-10 billing code upgrade. Also, I've cc'ed Mr. Murphy's new HC staffer, Chris Holt. Can you add him to your email dlist?

Thanks,

Brad Grantz | Congressman Tim Murphy (PA-18) | Legislative Director
322 Cannon House Office Building | Washington, DC 20515
(202) 225-2301 | (202) 225-1844
[Click here and sign up for Rep. Murphy's Weekly E-News](#)



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Paul Tonko
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tonko:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 PFS proposed rule was issued on July 8, 2013, with a 60-day comment period that closed on September 6, 2013. We appreciate your concerns and are carefully considering the public comments we received on proposed changes during the comment period before making a final policy decision and publishing the final rule. CMS will include its final policies in the CY 2014 PFS final rule with comment period, along with a summary of the comments received on the proposed rule and our responses. We anticipate issuing a final rule in the near future.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Tom Price ,M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Patrick Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

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Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Bill Posey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Posey:

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Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Leonard Lance
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lance:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive, flowing style.

Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 9 2013

The Honorable Frederica Wilson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wilson:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Donald Payne , Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Payne:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Jim Himes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Himes:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Joe Heck
U.S. House of Representatives
Washington, DC 20515

Dear Representative Heck:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Pat Meehan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meehan:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Michelle Lujan Grisham
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grisham:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Peter Roskam
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roskam:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Anna G. Eshoo
U.S. House of Representatives
Washington, DC 20515

Dear Representative Eshoo:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Pete Olson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Olson:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Aaron Schock
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schock:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Tom Marino
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marino:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Marc Veasey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Veasey:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Jackie Walorski
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walorski:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable David Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV -8 2013

The Honorable Mike Thompson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Tim Bishop
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Brett Guthrie
U.S. House of Representatives
Washington, DC 20515

Dear Representative Guthrie:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Brad Schneider
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schneider:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Peter King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

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Marilyn Tavenner



Administrator
Washington, DC 20201

NDV - 8 2013

The Honorable David McKinley
U.S. House of Representatives
Washington, DC 20515

Dear Representative McKinley:

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Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Joyce Beatty
U.S. House of Representatives
Washington, DC 20515

Dear Representative Beatty:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 PFS proposed rule was issued on July 8, 2013, with a 60-day comment period that closed on September 6, 2013. We appreciate your concerns and are carefully considering the public comments we received on proposed changes during the comment period before making a final policy decision and publishing the final rule. CMS will include its final policies in the CY 2014 PFS final rule with comment period, along with a summary of the comments received on the proposed rule and our responses. We anticipate issuing a final rule in the near future.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Dan Maffei
U.S. House of Representatives
Washington, DC 20515

Dear Representative Maffei:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Gerald Connolly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Connolly:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Eric Swalwell
U.S. House of Representatives
Washington, DC 20515

Dear Representative Swalwell:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV -8 2013

The Honorable Alan Lowenthal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lowenthal:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Larry Bucshon ,M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Julia Brownley
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brownley:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Ted Deutch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Deutch:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Marilyn Tavenner



Administrator
Washington, DC 20201

NOV - 8 2013

The Honorable Bill Flores
U.S. House of Representatives
Washington, DC 20515

Dear Representative Flores:

Thank you for your letter regarding our proposal to limit non-facility practice expense payment for certain services so that the total non-facility payment amount under the Medicare Physician Fee Schedule (PFS) would not exceed the total combined amount Medicare would pay for the same service in the facility setting and its effect on cancer care in the Calendar Year (CY) 2014 PFS proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

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Marilyn Tavenner

Congress of the United States
Washington, DC 20515

October 23, 2013

RECEIVED

Ms. Marilyn Tavenner
Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

OCT 28 2013
OFFICE OF
CORPORATE
MANAGEMENT

Dear Administrator Tavenner:

We write regarding the 2014 Medicare Physician Fee Schedule (MPFS) proposed rule, and in particular the proposal to cap certain 2014 MPFS payment rates at 2013 Hospital Outpatient Prospective Payment System (OPPS) payment rates (or 2013 Ambulatory Surgery Center (ASC) rates, if lower). If implemented, we are extremely concerned that this proposal could directly impact seniors' access to life-saving cancer treatments and increase costs for both seniors and Medicare.

Community cancer clinics across the country are struggling to keep their doors open due to inadequate reimbursements. Over the past 6 years, the Community Oncology Alliance (COA) has tracked the changing landscape of community cancer care.¹ During that period, 1,338 clinics have been impacted, most notably with 288 treatment facilities closing and 469 practices (typically having multiple treatment facilities) merging into or affiliating with hospitals. Just eight years ago, 87% of cancer care was provided in community cancer clinics.² By 2011, that had dropped to 67% and the shift to hospital-based cancer care accelerated in 2012 through 2013 due to a 20% increase in the rate of oncology clinic closings and hospital acquisitions.³ This has resulted in seniors with cancer losing access to cancer care close to home — particularly in rural areas.

CMS is proposing to cap 2014 payments to community cancer clinics using 2013 hospital payment rates not just for chemotherapy administration, but also for other essential cancer care services such as diagnostic imaging, therapeutic radiation, and pathology. CMS' proposal will cut payment for cancer care and, in the process, substantially widen the payment rate differential for cancer care services between settings. For example, under the proposed 2014 Medicare payment rules, community cancer clinics would be paid 50% less than hospital rates for a representative mix of chemotherapy administration services and 35% less than hospital rates for a representative mix of radiation therapy services.

¹ *Community Oncology Practice Impact Report*; Community Oncology Alliance, June 2013.

² *Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2001 for Medicare Fee-for-Service Beneficiaries*; The Moran Company, May 2013.

³ See *supra*, footnote 1.

We also note that many other areas of medicine would be adversely impacted by using 2013 OPPS rates to cap 2014 MPFS rates. For example, for interventional pain management services, ambulatory surgical centers would be paid at 53.3% of the OPPS schedule for the majority of procedures, whereas for some procedures it would be as low as 14%.

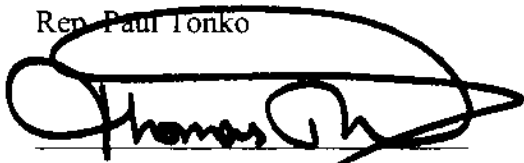
We urge CMS to not cut and cap payment cuts to cancer care and related medical services as proposed in 2014 MFPS. Like you, we share the goals of providing seniors access to cost-effective, quality cancer care and decreasing costs to Medicare.

Thank you for your attention to this important matter.

Sincerely,



Rep. Paul Tonko



Rep. Tom Price, M.D.



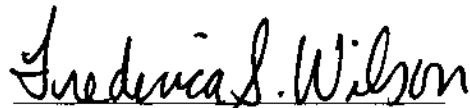
Rep. Patrick Tiberi



Rep. Bill Posey



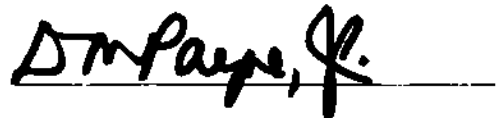
Rep. Leonard Lance




Rep. Frederica Wilson



Rep. Devin Nunes



Rep. Donald Payne, Jr.



Rep. Jim Himes



Rep. Joe Heck



Rep. Pat Meehan



Rep. Michelle Lujan Grisham

Marsha Blackburn

Rep. Marsha Blackburn

Peter Roskam

Rep. Peter Roskam

Anna G. Eshoo

Rep. Anna G. Eshoo

Gregg Harper

Rep. Gregg Harper

Pete Olson

Rep. Pete Olson

Aaron Schock

Rep. Aaron Schock

Tom Marino

Rep. Tom Marino

Marc Veasey

Rep. Marc Veasey

Jackie Walorski

Rep. Jackie Walorski

David Scott

Rep. David Scott

Mike Thompson

Rep. Mike Thompson

Tim Bishop

Rep. Tim Bishop

Brett Guthrie

Rep. Brett Guthrie

Brad Schneider

Rep. Brad Schneider

Peter King

Rep. Peter King

David McKinley

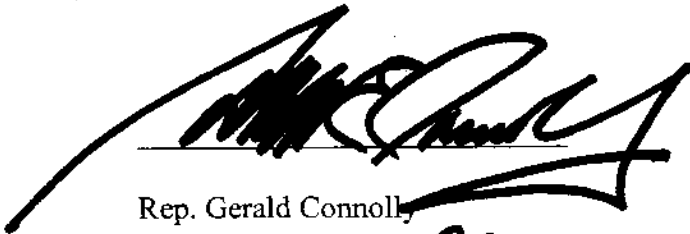
Rep. David McKinley

Joyce Beatty

Rep. Joyce Beatty

Dan Maffei

Rep. Dan Maffei



Rep. Gerald Connolly



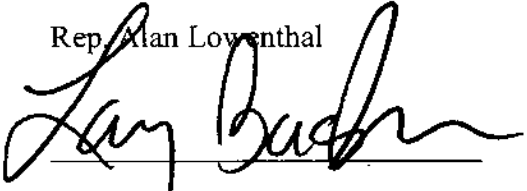
Rep. Renee Elmers



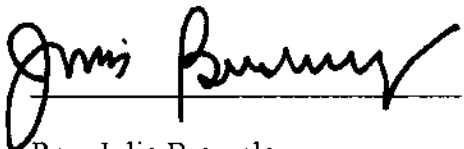
Rep. Eric Swalwell



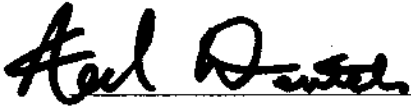
Rep. Alan Lowenthal



Rep. Larry Bucshon, M.D.



Rep. Julia Brownley



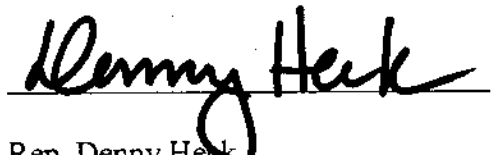
Rep. Ted Deutch



Rep. Bill Flores



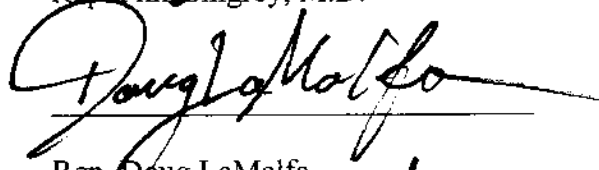
Rep. Steve Womack



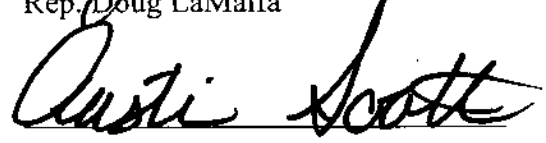
Rep. Denny Heck



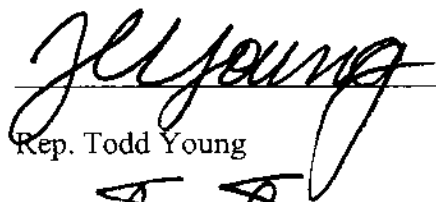
Rep. Phil Gingrey, M.D.



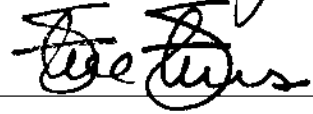
Rep. Doug LaMalfa



Rep. Austin Scott



Rep. Todd Young



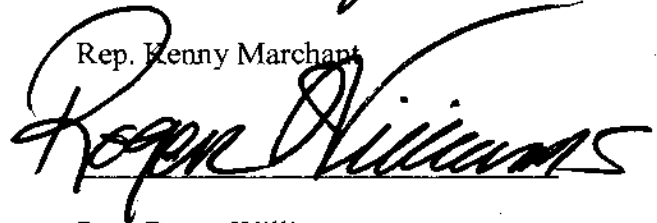
Rep. Steve Stivers



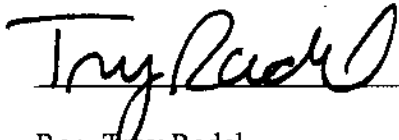
Rep. Ron Barber



Rep. Kenny Marchant



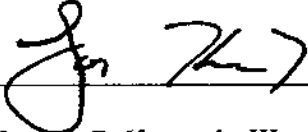
Rep. Roger Williams



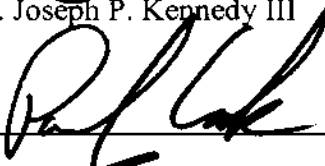
Rep. Trey Radel



Rep. Bill Cassidy, M.D.



Rep. Joseph P. Kennedy III




Rep. Paul Cook



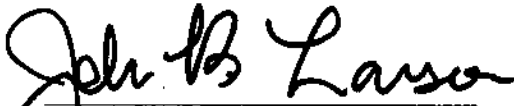
Rep. Tim Griffin



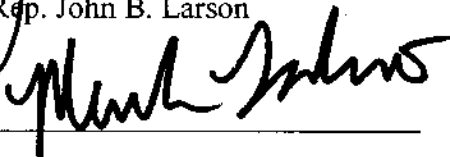
Rep. Matt Cartwright



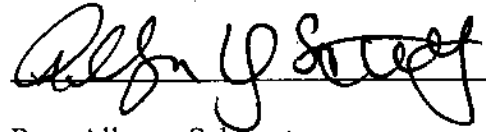
Rep. Alan Nunnelee



Rep. John B. Larson



Rep. Mark Takano



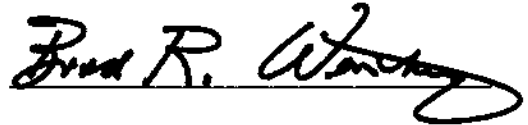
Rep. Allyson Schwartz



Rep. Terri Sewell



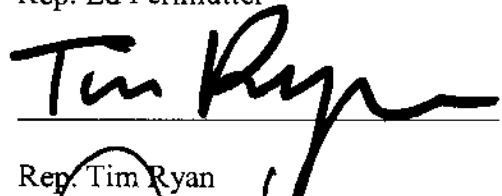
Rep. Adam Kinzinger



Rep. Brad Wenstrup



Rep. Ed Perlmutter



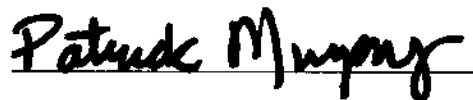
Rep. Tim Ryan



Rep. Jared Polis



Rep. Ron Kind



Rep. Patrick Murphy

Dave Loeb sack

Rep. Dave Loeb sack

Billy Long

Rep. Billy Long

Bill Johnson

Rep. Bill Johnson

Richard Nugent

Rep. Richard Nugent

Vern Buchanan

Rep. Vern Buchanan

Mike Rogers

Rep. Mike Rogers

Sheila Jackson Lee

Rep. Sheila Jackson Lee

Ed Whitfield

Rep. Ed Whitfield

Lois Capps

Rep. Lois Capps

David P. Joyce

Rep. David Joyce

Gloria Negrete McLeod

Rep. Gloria Negrete McLeod

Michael Honda

Rep. Michael Honda

Rodney Davis

Rep. Rodney Davis

Joe Barton

Rep. Joe Barton

Stephen Lynch

Rep. Stephen Lynch

Greg Walden

Rep. Greg Walden

Jim Matheson

Rep. Jim Matheson

Pete Sessions

Rep. Pete Sessions

Michael R. Turner

Rep. Michael R. Turner

Bruce Braley

Rep. Bruce Braley

Don Young

Rep. Don Young

Michael Burgess M.D.

Rep. Michael Burgess, M.D.

Virginia Foxx

Rep. Virginia Foxx

Alcee Hastings

Rep. Alcee Hastings

Bill Pascrell Jr.

Rep. Bill Pascrell, Jr.

Adam B. Schiff

Rep. Adam Schiff

Linda J. Sanchez

Rep. Linda Sanchez

Hank Johnson

Rep. Henry C. "Hank" Johnson

Howard P. "Buck" McKeon

Rep. Howard P. "Buck" McKeon

Patrick J. McHenry

Rep. Patrick McHenry

Carolyn McCarthy

Rep. Carolyn McCarthy

Yvette D. Clarke

Rep. Yvette D. Clarke

Diana DeGette

Rep. Diana DeGette

Ralph M. Hall

Rep. Ralph Hall

C.A. Dutch Ruppensberger

Rep. C.A. Dutch Ruppensberger

Jim Gerlach

Rep. Jim Gerlach

Ben Ray Lujan

Rep. Ben Ray Lujan

Andre Carson

Rep. André Carson

Brian Higgins

Rep. Brian Higgins

Charles W. Boustany, Jr.

Rep. Charles W. Boustany, Jr. M.D.

Joe Garcia

Rep. Joe Garcia

Lee Terry
Lee Terry

Robert Latta

Rep. Robert Latta

Steve Israel

Rep. Steve Israel

Gene Green

Rep. Gene Green

Derek Kilmer

Rep. Derek Kilmer

Carol Shea-Porter

Rep. Carol Shea-Porter

David Reichert
David Reichert



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Robert E. Andrews
U.S. House of Representatives
Washington, DC 20515

Dear Representative Andrews:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

We agree that scientific peer-reviewed journal reprints, supplements, and medical textbooks are educational to physicians. We also appreciate the importance of reprints, supplements, and medical textbooks in potentially improving quality of patient care. However, we do not believe these materials fall within the statutory exclusion. Section 1128G(e)(10)(B)(iii) of the Social Security Act allows applicable manufacturers to exclude from the reporting requirements payments or other transfers of value in the form of educational materials that *directly benefit patients or are intended for patient use*. As stated in the preamble to the final rule, "Although these items may have downstream benefits for a patient, we believe they are not directly beneficial to patients nor are they intended for patient use..." as required by the statutory exclusion. However, education materials, such as wall models and anatomical models that are intended to be used with the patient—and therefore directly benefit the patient—are excluded from Open Payments reporting requirements.

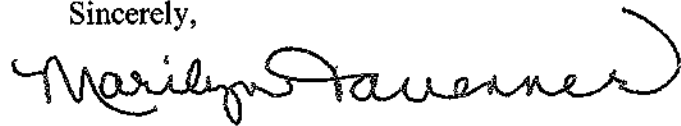
As discussed in our final rule, the mere existence of a financial relationship between the industry and physicians does not necessarily signify an inappropriate relationship. Disclosure alone is not sufficient to differentiate beneficial financial relationships from those that potentially create conflicts of interest. Nor, for that matter, should the inclusion of any particular type of payment or transaction on Open Payments be interpreted as any comment by the federal government on the societal value or appropriateness of a particular type of payment. Rather, Open Payments provides broad transparency to the nature and extent of relationships, providing consumers with the information needed to ask questions and to make more informed decisions. The Open Payments program is not meant to encourage or discourage any particular transaction or type of transaction; it simply reports the information in a neutral and non-judgmental way for the use of physicians, patients, researchers, or any other member of the public.

Applicable manufacturers reporting payments or other transfers of value are required to select the nature of payment category they believe most accurately describes a payment or other transfer of value. One nature of payment category available is the “education” category. CMS has clarified in sub-regulatory guidance that this category generally includes payments or other transfers of value that involve the imparting or acquiring of particular knowledge or skills, which can include medical textbooks and journal reprints provided to physicians. Another nature of payment category available is the “gift” category, depending on the circumstances of the transfer of value.

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Again, thank you for your continued interest in this program. Our response has been sent to each of the co-signers. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Michael Burgess
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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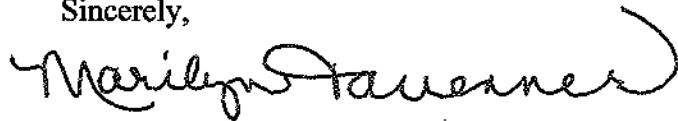
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Allyson Schwartz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schwartz:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

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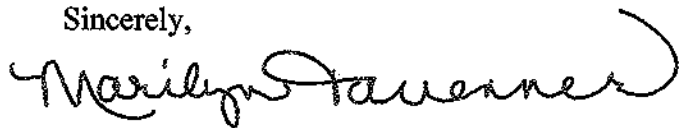
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Richard E. Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

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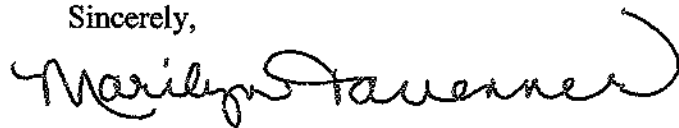
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Patrick Meehan
U.S. House of Representatives
Washington, DC 20515

Dear Representative Meehan:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

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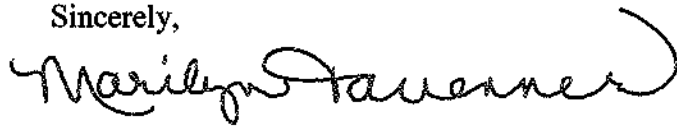
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Andy Harris
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harris:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

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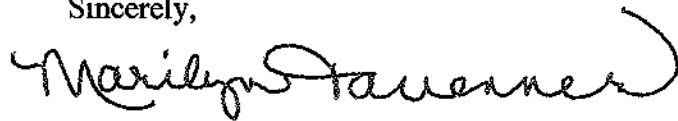
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Phil Gingrey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gingrey:

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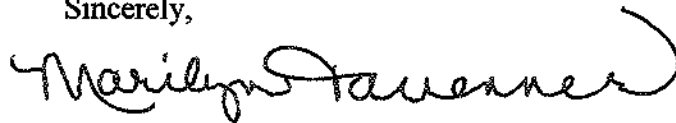
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Paul Broun
U.S. House of Representatives
Washington, DC 20515

Dear Representative Broun:

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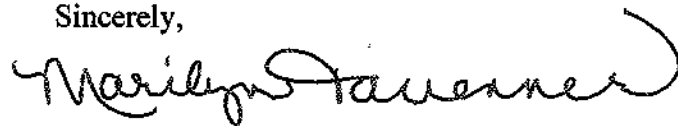
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

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DEC 23 2013

The Honorable Phil Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representative Roe:

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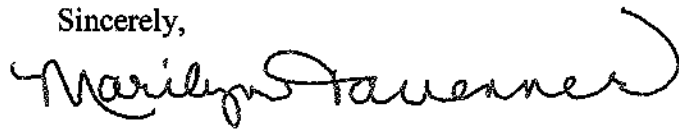
Page 2 – The Honorable Phil Roe

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Again, thank you for your continued interest in this program. Our response has been sent to each of the co-signers. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Michael Turner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Turner:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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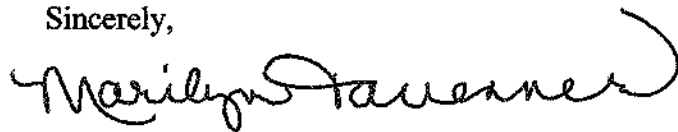
Page 2 – The Honorable Michael Turner

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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable John F. Tierney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tierney:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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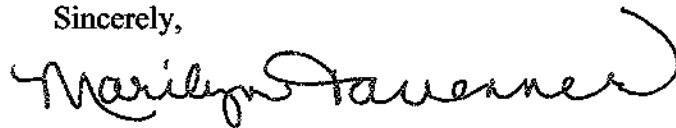
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Michael Capuano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capuano:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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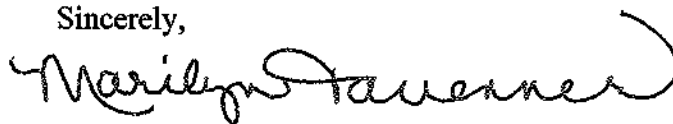
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Charles W. Boustany, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Boustany, Jr.:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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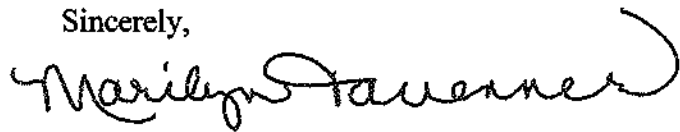
Page 2 – The Honorable Charles W. Boustany, Jr.

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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Charles Rangel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rangel:

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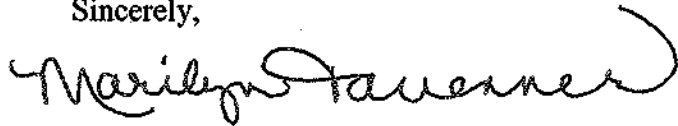
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Dan Benishek
U.S. House of Representatives
Washington, DC 20515

Dear Representative Benishek:

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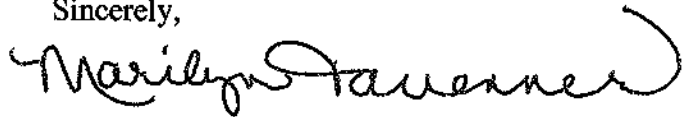
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Kathy Castor
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castor:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

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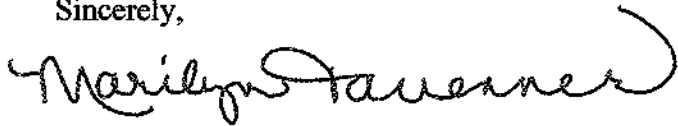
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Robert Brady
U.S. House of Representatives
Washington, DC 20515

Dear Representative Brady:

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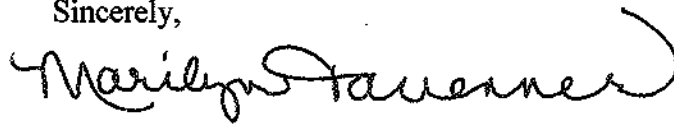
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Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Ann Wagner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wagner:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

We agree that scientific peer-reviewed journal reprints, supplements, and medical textbooks are educational to physicians. We also appreciate the importance of reprints, supplements, and medical textbooks in potentially improving quality of patient care. However, we do not believe these materials fall within the statutory exclusion. Section 1128G(e)(10)(B)(iii) of the Social Security Act allows applicable manufacturers to exclude from the reporting requirements payments or other transfers of value in the form of educational materials that *directly benefit patients or are intended for patient use*. As stated in the preamble to the final rule, "Although these items may have downstream benefits for a patient, we believe they are not directly beneficial to patients nor are they intended for patient use..." as required by the statutory exclusion. However, education materials, such as wall models and anatomical models that are intended to be used with the patient—and therefore directly benefit the patient—are excluded from Open Payments reporting requirements.

As discussed in our final rule, the mere existence of a financial relationship between the industry and physicians does not necessarily signify an inappropriate relationship. Disclosure alone is not sufficient to differentiate beneficial financial relationships from those that potentially create conflicts of interest. Nor, for that matter, should the inclusion of any particular type of payment or transaction on Open Payments be interpreted as any comment by the federal government on the societal value or appropriateness of a particular type of payment. Rather, Open Payments provides broad transparency to the nature and extent of relationships, providing consumers with the information needed to ask questions and to make more informed decisions. The Open Payments program is not meant to encourage or discourage any particular transaction or type of transaction; it simply reports the information in a neutral and non-judgmental way for the use of physicians, patients, researchers, or any other member of the public.

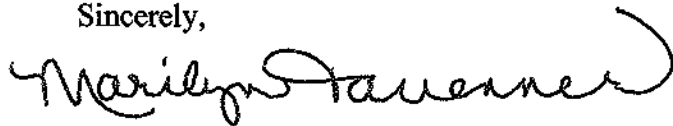
Page 2 – The Honorable Ann Wagner

Applicable manufacturers reporting payments or other transfers of value are required to select the nature of payment category they believe most accurately describes a payment or other transfer of value. One nature of payment category available is the “education” category. CMS has clarified in sub-regulatory guidance that this category generally includes payments or other transfers of value that involve the imparting or acquiring of particular knowledge or skills, which can include medical textbooks and journal reprints provided to physicians. Another nature of payment category available is the “gift” category, depending on the circumstances of the transfer of value.

We are continuously examining this and other issues to ensure policy is aligned with the vision and intention of the Affordable Care Act section 6002, Transparency Reports and Reporting of Physician Ownership or Investment Interest.

Again, thank you for your continued interest in this program. Our response has been sent to each of the co-signers. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Paul Gosar
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gosar:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

We agree that scientific peer-reviewed journal reprints, supplements, and medical textbooks are educational to physicians. We also appreciate the importance of reprints, supplements, and medical textbooks in potentially improving quality of patient care. However, we do not believe these materials fall within the statutory exclusion. Section 1128G(e)(10)(B)(iii) of the Social Security Act allows applicable manufacturers to exclude from the reporting requirements payments or other transfers of value in the form of educational materials that *directly benefit patients or are intended for patient use*. As stated in the preamble to the final rule, "Although these items may have downstream benefits for a patient, we believe they are not directly beneficial to patients nor are they intended for patient use..." as required by the statutory exclusion. However, education materials, such as wall models and anatomical models that are intended to be used with the patient—and therefore directly benefit the patient—are excluded from Open Payments reporting requirements.

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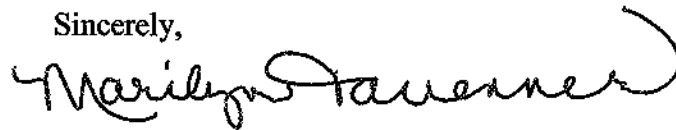
Page 2 – The Honorable Paul Gosar

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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Marsha Blackburn
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) regarding the February 2013 final rule implementing the Physician Payments Sunshine Act, now known as Open Payments (Affordable Care Act Section 6002).

In your letter, you expressed concerns with how the rule defines medical textbooks and the reprints of medical journal articles, as reportable to the Secretary of Health and Human Services. You also discussed your concern that having these items reported would prevent the timely distribution of the information to clinicians. You asked CMS specifically to place textbooks and scientific peer-reviewed medical journal materials among the items excluded from Open Payments reporting requirements.

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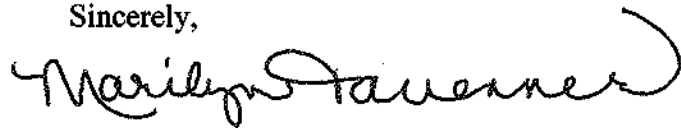
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Michael Fitzpatrick
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fitzpatrick:

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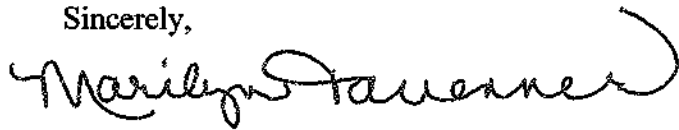
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Marilyn Tavenner



Administrator
Washington, DC 20201

DEC 23 2013

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

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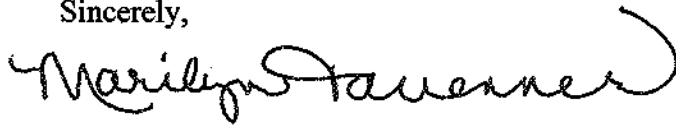
Page 2 – The Honorable Bill Johnson

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Marilyn Tavenner

Congress of the United States
Washington, DC 20515

November 22, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1454-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

The undersigned Members of Congress write to express our concerns with regulations recently promulgated by the Centers for Medicare and Medicaid Services (CMS) under the Sunshine Act and their impact on scientific peer reviewed medical journals and textbooks. We believe these regulations are contrary to congressional intent and will adversely impact patient care as well as ongoing medical education.

The Sunshine Act was designed to promote transparency for payments and other financial transfers of value between physicians and the medical product industry. As part of this provision, Congress outlined twelve specific exclusions from the reporting requirement, including *“[e]ducational materials that directly benefit patients or are intended for patient use.”* In its interpretation of the statute, CMS concluded that medical textbooks, reprints of peer-reviewed scientific clinical journal articles, journal supplements and abstracts of journal articles are “not directly beneficial to patients, nor are they intended for patient use.” This conclusion is inconsistent with the statutory language on its face, congressional intent, and the reality of clinical practice where patients benefit directly from improved physician medical knowledge.

The importance of up-to-date, peer-reviewed scientific medical information as the foundation for good medical care is well documented. Medical textbooks and scientific peer-reviewed journal supplements and reprints have long been considered essential tools for clinicians to remain informed about the latest in medical practice and patient care. Independent, peer-reviewed medical textbooks and journal article reprints represent the gold standard in evidence-based medical knowledge and provide a direct benefit to patients because better informed clinicians render better care to their patients. Moreover, Congress included a specific exclusion of items that directly benefit patients, such as reference materials that are often used side-by-side with a patient as a first resource when a patient brings an unfamiliar medical issue to a clinician. Many medical textbooks and scientific medical journal reprints are used in this way by physicians. The design of the reporting requirement presents a clear disincentive for clinicians to accept high quality, independent educational materials, an outcome that was unintended when the provision was passed into law.

The Food and Drug Administration (FDA)’s 2009 industry guidance titled “Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices” underscores the importance of this scientific peer reviewed information. The FDA

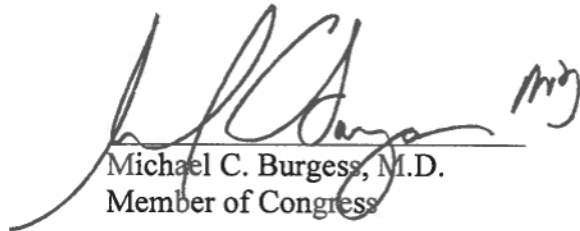
noted the “important public health and policy justification supporting dissemination of truthful and non-misleading medical journal articles and medical or scientific reference publications.” FDA guidelines for reprints provide that medical reprints should be distributed separately from information that is promotional in nature, specifically because the reprints are designed to promote the science of medicine, are educational, and intended to benefit patients. We believe the Sunshine Act was designed to support the dissemination of this type of educational material.

We are concerned that the final regulations could inadvertently prevent the timely distribution of rigorous scientifically reviewed medical information to clinicians and patients and thereby undermine efforts to improve the quality of care provided to patients. This was not the intent of Congress when the Sunshine Act was passed, as evidenced by statutory language. We request a meeting with Dr. Jonathan Blum, Principal Deputy Administrator and Director, to discuss these matters, to urge the reversal of this policy, and specifically to place textbooks and scientific peer reviewed medical journal materials among the items excluded from the Sunshine Act’s reporting requirement. These materials are critical for patient care as intended by Congress.

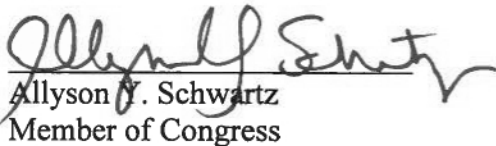
Sincerely,



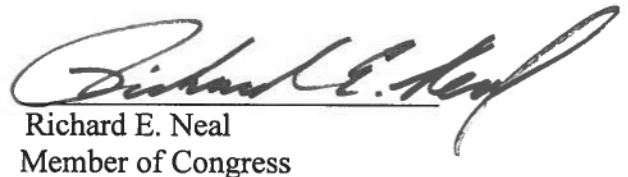
Robert E. Andrews
Member of Congress



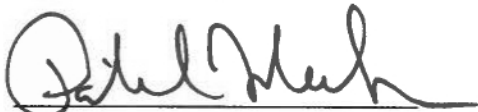
Michael C. Burgess, M.D.
Member of Congress



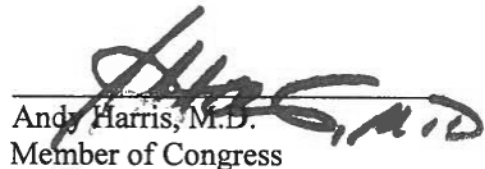
Allyson Y. Schwartz
Member of Congress



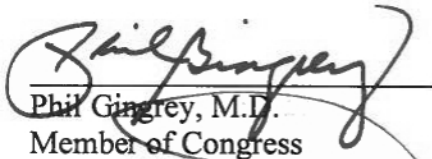
Richard E. Neal
Member of Congress



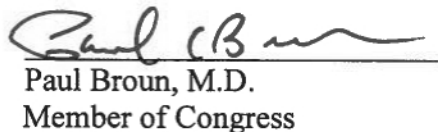
Pat Meehan
Member of Congress



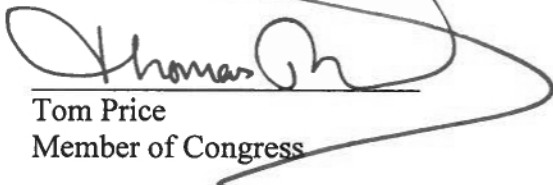
Andy Harris, M.D.
Member of Congress



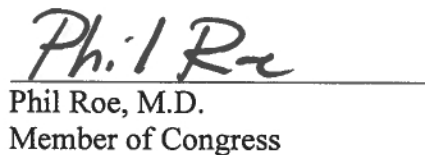
Phil Gingrey, M.D.
Member of Congress



Paul Broun, M.D.
Member of Congress



Tom Price
Member of Congress



Phil Roe, M.D.
Member of Congress

Michael R. Turner

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Member of Congress

Mike Fitzpatrick

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Member of Congress

John F. Tierney

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Member of Congress

Michael E. Capuano

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Marsha Blackburn

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Paul A. Gosar

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Member of Congress

Charles W. Boustany, Jr.

Charles W. Boustany, Jr., M.D.
Member of Congress

Charles B. Rangel

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Member of Congress

Dan Benishek

Dan Benishek, M.D.
Member of Congress

Bill Johnson

Bill Johnson
Member of Congress

Kathy Castor

Kathy Castor
Member of Congress

Robert A. Brady

Robert Brady
Member of Congress

Ann Wagner

Ann Wagner
Member of Congress

Cc:

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services

Dr. Jonathan Blum
Principal Deputy Administrator and Director
Centers for Medicare and Medicaid Services

Dr. Shantanu Agrawal
Office of Corporate Integrity



JAN - 8 2016

Administrator

Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding the proposed regulation entitled "*Medicare Program; Medicare Clinical Diagnostic Laboratory Tests Payment System*," which was published in the Federal Register on October 1, 2015. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your sharing your views on this issue.

You expressed a number of concerns about our proposals to implement section 216 of the Protecting Access to Medicare Act of 2014 related to implementation timeframes, the range of laboratories that would be required to report private payer data to CMS, and how Advanced Diagnostic Laboratory Tests would be defined. You urged CMS to delay implementation of the rule and to work with affected laboratory, physician, hospital and beneficiary communities to resolve concerns about the proposed policy. As we are preparing the final rule, we will fully consider the issues raised in your letter as well as the many comments we received during the public comment period for the proposed rule, which ended on November 24, 2015.

We appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator

Congress of the United States
Washington, DC 20515

December 16, 2015

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

We are writing to express our concerns with the Medicare Clinical Diagnostic Laboratory Tests Payment System Proposed Rule, published in the *Federal Register* on October 1, 2015. We are primarily concerned that laboratories will be unable to comply with the proposed implementation timeline. Delays in the rulemaking process, which the statute required to be completed by June 30, 2015, provide laboratories with little time to begin undertaking significant data collection. We respectfully request that you make the necessary changes so the final rule reflects the intent of Congress, and adjust the implementation timeline to provide the necessary time for laboratories to comply. It is critical that the Centers for Medicare & Medicaid Services (CMS) engage in a constructive dialogue with stakeholders on ways to improve the proposed rule and establish a clear path forward for the clinical laboratory community, clinicians, and the millions of Medicare beneficiaries who rely on its services.

The Protecting Access to Medicare Act of 2014 (PAMA) (P. L. 113-93) includes the most significant reforms to the Clinical Laboratory Fee Schedule (CLFS) since it was established in 1984. PAMA requires the development of a first-of-its-kind, mandatory reporting system in which “applicable laboratories” must report all of their private payment rates and test volumes to CMS. The goal of this new reporting system is to develop a market-based reimbursement system to replace the current fee schedule. Clinical laboratories ranging from community independent laboratories, physician office laboratories, hospital-based laboratories, national laboratories, and other laboratories would report private market data, and CMS would calculate median rates so that Medicare rates could be reset based on a true picture of the laboratory market.

However, under CMS’s current proposal, a number of laboratories are prohibited from participating in the reporting process. We are deeply concerned that this prohibition will skew the market data, resulting in Medicare rates that are not reflective of true market prices. We recommend that CMS consider a more inclusive approach to determining which laboratories should report data and to allow any laboratory to voluntarily report data.

In addition to the need to broaden the universe of reporting laboratories, CMS must reconsider the proposed timeline. Laboratories will be establishing new information systems to collect, assess, and validate data sets according to regulations that have yet to be finalized, and then quickly reporting the data to CMS beginning in January 2016. Failure to meet this deadline or

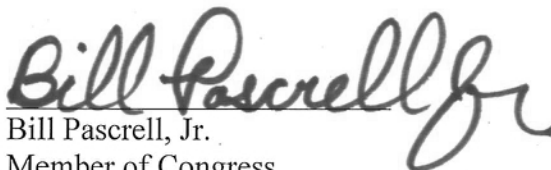
errors in reporting could yield penalties of up to \$10,000 per day. The proposed timeline presents a significant challenge to the laboratory community as it provides little time to prepare, certify, and submit upwards of millions of data points based on a yet-to-be-released set of Agency requirements. Accurate reporting is essential to establishing appropriate reimbursement rates. Additionally, we encourage CMS to provide greater time between the publication of revised reimbursement rates and their effective date as well as outline a formal process for laboratories to call attention to potential errors in calculating the rates.

Additionally, PAMA also creates a new category of tests, Advanced Diagnostic Laboratory Tests (ADLTs). In order to be considered an ADLT, a test must analyze multiple biomarkers of "DNA, RNA, or proteins," among other factors. Despite this clear language, the proposed rule excludes "proteins" from the criteria. Protein-based diagnostics are being used to make clinical decisions regarding patient care today, and encouraging further development in this area is crucial. CMS should revise the ADLT definition to reflect the statute's inclusion of proteins.

As the Agency works to finalize the rule, we ask that CMS make changes to the proposed policy to reflect Congressional intent, provide clinical laboratories with sufficient time to implement these important changes, and preserve market competition to ensure continued access to laboratory services.

We urge CMS to work with Congress as well as the laboratory and beneficiary communities affected by the rule to resolve these concerns. Thank you for consideration of our request. We look forward to your timely response.

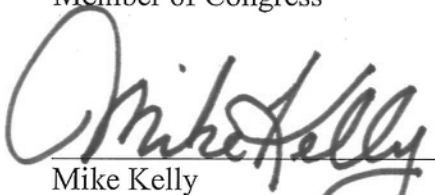
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Bill Pascrell, Jr.
Member of Congress



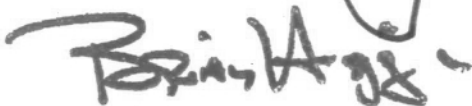
Patrick Meehan
Member of Congress



Mike Kelly
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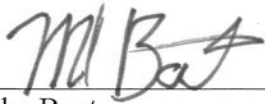
Bill Shuster
Member of Congress




Brian Higgins
Member of Congress



Chris Stewart
Member of Congress



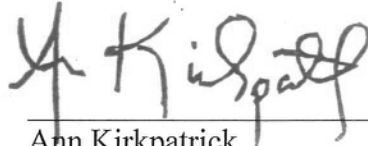
Mike Bost
Member of Congress



Chris Collins
Member of Congress



Peter T. King
Member of Congress



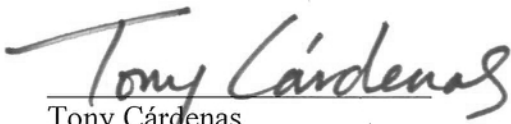
Ann Kirkpatrick
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André Carson
Member of Congress



Gus M. Bilirakis
Member of Congress



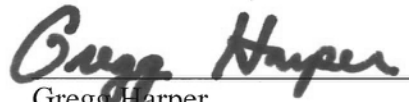
Tony Cárdenas
Member of Congress



Steven M. Palazzo
Member of Congress



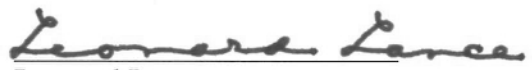
Renee L. Ellmers
Member of Congress



Gregg Harper
Member of Congress



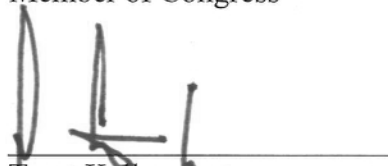
Mike Thompson
Member of Congress



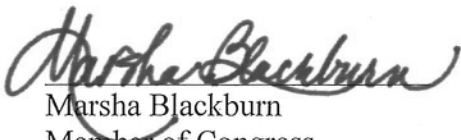
Leonard Lance
Member of Congress



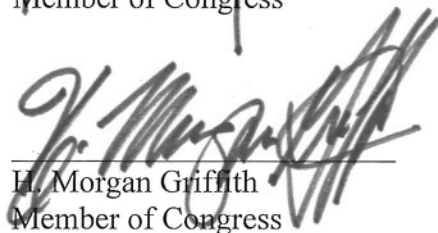
Duncan Hunter
Member of Congress



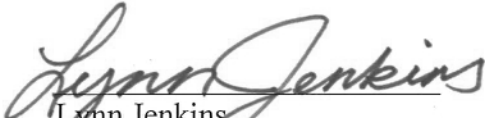
Trent Kelly
Member of Congress




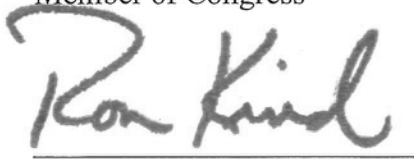
Marsha Blackburn
Member of Congress



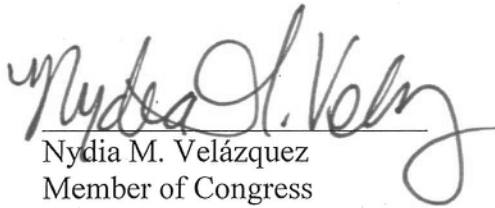
H. Morgan Griffith
Member of Congress



Lynn Jenkins
Member of Congress


Ryan A. Costello
Member of Congress

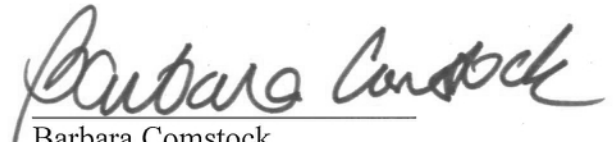

Ron Kind
Member of Congress

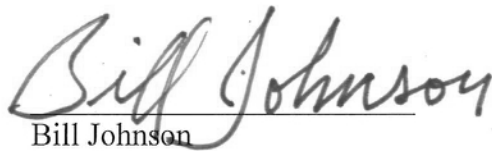

Peter A. DeFazio
Member of Congress


Nydia M. Velázquez
Member of Congress



George Holding
Member of Congress



Patrick J. Tiberi
Member of Congress

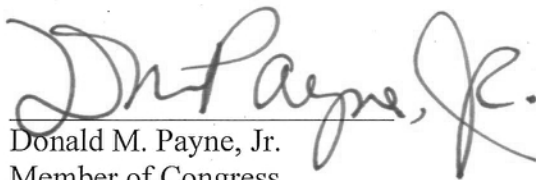

Barbara Comstock
Member of Congress



Bill Johnson
Member of Congress

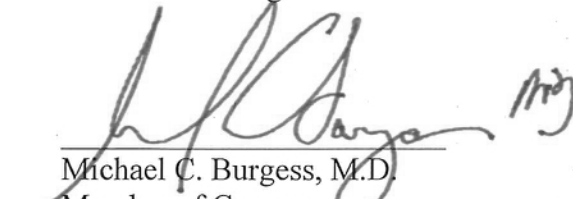

Mike Fitzpatrick
Member of Congress

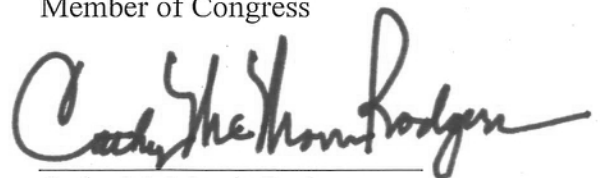

Betty McCollum
Member of Congress


David E. Price
Member of Congress


Donald M. Payne, Jr.
Member of Congress


Scott H. Peters
Member of Congress


Michael C. Burgess, M.D.
Member of Congress

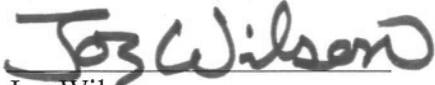

Cathy McMorris Rodgers
Member of Congress



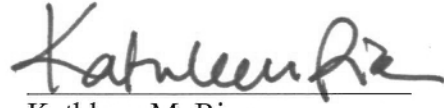
Tom Price, M.D.
Member of Congress



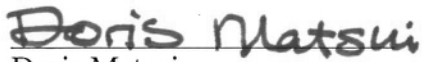
Brett Guthrie
Member of Congress



Joe Wilson
Member of Congress



Kathleen M. Rice
Member of Congress



Doris Matsui
Member of Congress



Susan W. Brooks
Member of Congress



Administrator
Washington, DC 20201

FEB 26 2016

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter concerning the Centers for Medicare & Medicaid Services' (CMS) draft electronic clinical quality measure (eCQM), "Non-Recommended Prostate-Specific Antigen (PSA)-Based Screening".

Mathematica Policy Research is developing this appropriate use measure under contract with CMS with the intent to reduce inappropriate use of PSA-based screening. The harm of unnecessary testing can lead to overtreatment or over-diagnosis of prostate cancer, which may outweigh the possible benefits. As with all measures being developed, broad stakeholder input is solicited through public comment and other means early in the measure development process, and feedback is collected throughout the measure development life cycle. There is a multi-step pre-rulemaking process to solicit feedback, and if a determination is made that the measure is appropriate for a particular program, it is then subject to notice and comment rulemaking. This eCQM was on the Measure under Consideration list in 2015, which was then presented to the Measure Application Partnership in December, 2015 for comment and discussion.

We appreciate your comments and feedback on the draft eCQM "Non-Recommended PSA-Based Screening." We have heard concerns and recommendations from many stakeholders. Based on this feedback, CMS will continue to work with specialty societies, as well as engage additional members of the community, such as providers and patients. By taking the time to engage stakeholders in reviewing the electronic specifications, we can then determine the path forward for this eCQM.

We seek to develop quality measures that facilitate effective, safe, efficient, patient-centered, equitable, and timely care. CMS looks forward to working with you on this important issue. Please do not hesitate to let us know if you have any further questions. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt", is positioned above the typed name.

Andrew M. Slavitt
Acting Administrator

Congress of the United States

Washington, DC 20515

December 14, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Mr. Slavitt:

The members of the GOP Doctors Caucus urge you to withdraw the draft CMS clinical quality measure developed by Mathematica Policy Research on "Non-Recommended PSA-Based Screening." We are highly concerned that the measure puts United States Preventive Services Task Force (USPSTF) recommendations against prostate cancer screening before a man's right to discuss prostate cancer screening with his physician. Furthermore, we find it unsettling that CMS is interjecting itself in the ongoing scientific debate regarding the appropriate role of prostate-specific antigen in prostate cancer screening.

As you are aware, the Mathematica "Non-Recommended PSA-Based Screening" quality measure is intended to discourage the use of PSA-based screening for prostate cancer. Based on the highly controversial 2012 recommendations from the USPSTF, the measure will identify physicians who order a PSA-based screening test as low quality. All prostate cancer screening with PSA will be considered inappropriate regardless of the patient's wishes or risk of developing prostate cancer.

By identifying physicians who screen for prostate cancer as low quality, this rule will create a perverse incentive for primary care providers to ignore the recommendations of the majority of prostate cancer screening guidelines. Prostate cancer screening guidelines from the American Cancer Society, American College of Physicians, American Society of Clinical Oncology, American Urological Association, and the National Comprehensive Cancer Network all recommend that men engage with their physicians in a shared decision-making process to determine whether to be screened for prostate cancer. Unlike USPSTF recommendations that reject all prostate cancer screening regardless of individual values or risk factors for developing prostate cancer, these well-respected organizations recognize that individual considerations are critical to this decision-making process.

The recommendations of these organizations stand in sharp contrast to the USPSTF recommendations requiring that all men make the same decision to decline prostate cancer screening, regardless of their risk factors. Under this guideline, even men who are known to have an increased risk of prostate cancer, including African-American men and men with a family history of prostate cancer, would be effectively denied the choice to be screened for this potentially lethal disease.

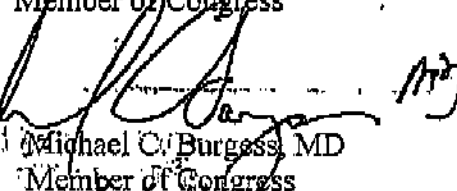
While reasonable men and their physicians may make different choices about whether to be screened for prostate cancer, it is troubling that CMS would consider a rule that denigrates an evidence-based decision made by millions of men each year that is supported by highly respected medical societies. The truth about PSA and prostate cancer screening is that there is no consensus on the truth. Like many aspects of medical care, there is debate regarding when it is and is not appropriate to screen for prostate cancer and ongoing research will likely settle this debate in the future.

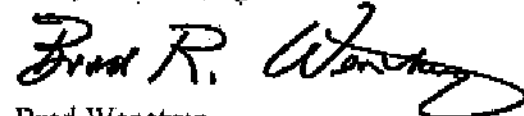
Given this healthy debate among medical experts, it is puzzling that CMS has ruled in favor of the USPSTF recommendations and against those of other organizations. Is CMS privy to clinical data that others are not aware of, including prostate cancer specialists at Memorial Sloan-Kettering, MD Anderson, Harvard, Johns Hopkins, Vanderbilt, the Mayo Clinic and others who support prostate cancer screening? Although we assume that CMS is more interested in getting the medical-science-right for our seniors, the decision to codify one side of the debate into a quality performance measure is, at best, reckless and premature.

As elected officials we understand the need to maximize value for the health care dollars spent by taxpayers. But as health care providers with decades of experience helping patients make difficult diagnostic and treatment choices, we also understand that the opportunity for quality improvement is not uniform across the spectrum of medical decision-making. Therefore, we strongly urge CMS to withdrawal this proposed Mathematica "Non-Recommended PSA-Based Screening" quality measure. It is irresponsible to impose bureaucratic quality mandates discouraging a man from choosing to be screened for prostate cancer when there is credible medical evidence supporting his decision to do so.

Sincerely,

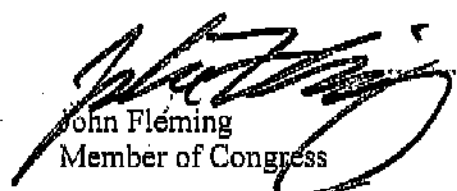

David P. Roe
Member of Congress

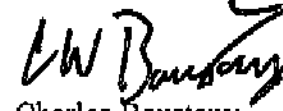

Michael C. Burgess, MD
Member of Congress

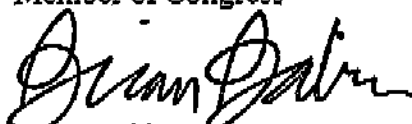

Brad Wenstrup
Member of Congress

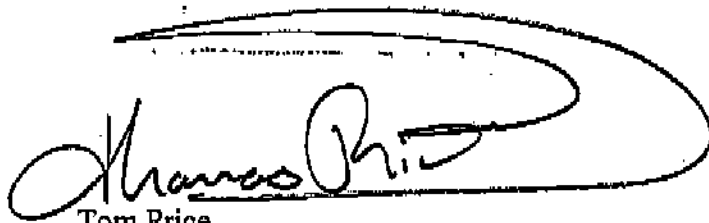

Larry Bucshon
Member of Congress


John Boozman
U.S. Senate


John Fleming
Member of Congress


Charles Boustany
Member of Congress

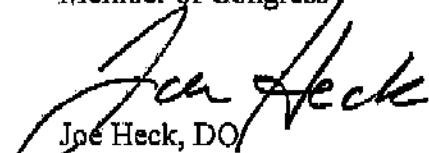

Brian Babin
Member of Congress



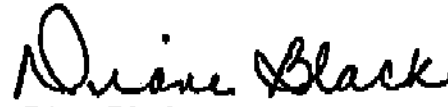
Tom Price
Member of Congress



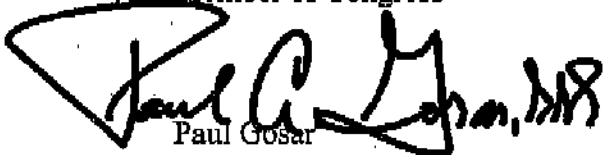
Ralph Abraham
Member of Congress



Joe Heck, DO
Member of Congress



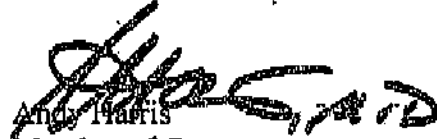
Diane Black
Member of Congress



Paul Gosar
Member of Congress



Dan Benishek
Member of Congress



Andy Harris
Member of Congress



Scott DesJarlais
Member of Congress



JAN 21 2009

7500 Security Boulevard
Baltimore, MD 21244-1850

The Honorable Heath Shuler
House of Representatives
Washington, DC 20515

Dear Mr. Shuler:

Thank you for your letter regarding the new oxygen payment regulations published in the 2009 Medicare Physician Fee Schedule rule on November 19, 2008. I appreciate you contacting me to share your concerns regarding these important changes in Medicare.

As noted in the preamble, the new regulations implement requirements set forth in the law under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The statutory effective date of the changes required by MIPPA, including the 36-month oxygen rental cap, was January 1, 2009. Although the MIPPA requirements are largely self-implementing and provide the Centers for Medicare & Medicaid Services (CMS) with little to no discretion, MIPPA allowed for some discretion in that it gave the Secretary of the Department of Health and Human Services the authority to pay for maintenance and servicing of oxygen equipment after the 36 month rental cap if the Secretary determines that such payments are reasonable and necessary. Pursuant to this authority, Medicare will pay for one, in-home, routine maintenance and servicing visit for oxygen concentrators and transfilling equipment every 6 months during 2009 only, beginning six months after the end of the 36-month rental period. In the rule, we solicited comments about whether these maintenance and servicing payments should continue after 2009.

One important purpose of the rule is to solicit comments on the regulations from interested parties. We have already received many responses, including some that express concerns similar to yours. We will continue to review the policies on suppliers furnishing oxygen equipment and can assure you that all comments received during the comment period will be considered. I would also note that CMS has made a significant effort to educate both suppliers and beneficiaries about the changes to ensure continued access to oxygen therapy.

Thank you for your interest in this matter. Again, I appreciate you contacting CMS about this important matter.

Sincerely,

Laurence D. Wilson

Director
Chronic Care Policy Group
Center for Medicare Management

12/17/2008 4:01P

Congress of the United States
Washington, DC 20515

December 16, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave. SW
Hubert Humphrey Building Room
Washington, DC 20024

Dear Acting Administrator Weems:

We are writing today to ask that the Centers for Medicare and Medicaid Services (CMS) delay the final rule capping Medicare reimbursements to home oxygen suppliers at 36 months, which is due to go into effect on January 1, 2009.

As you know, previous to the Deficit Reduction Act of 2005, oxygen equipment was rented to patients through Medicare on a continuous rental basis. However, a provision in the Deficit Reduction Act limited monthly rental payments to oxygen suppliers to 36 months of continuous use. After 36 months, the title of the equipment would be transferred to the patient.

This raised many concerns, since the administration of oxygen is sensitive, and the maintenance and repair of the equipment is complex. Patients may not be able to afford to have their equipment serviced or have their supplier come help them with the equipment, which could compromise their health and safety. It would also presumably increase the number of emergency room visits as a result of improper or inadequate equipment upkeep.

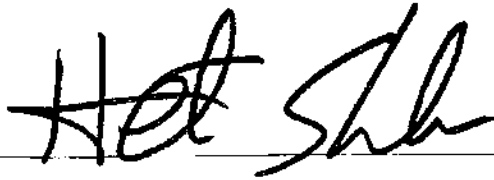
In an effort to avoid these potential problems, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included a repeal of this provision, leaving ownership with the oxygen supplier. Congress instructed CMS to establish adequate payments for continued care of these patients after the 36-month period. However, when CMS published the final rule it continued to cap the number of months that an oxygen supplier would receive monthly rental reimbursements at 36 months, requiring suppliers to shoulder the burden of maintaining and repairing equipment for the remainder of the reasonable life of the equipment. The rule establishes inadequate maintenance and service payments equal to only two 30 minute visits annually at a payment rate of approximately \$30 per visit. In addition, the rule requires the original oxygen provider to continue to provide oxygen therapy for those patients who move out of the original oxygen provider's service area for the rest of the reasonable life of the equipment.

This rule does not take into account unscheduled or emergency repairs or the replacement of supplies associated with the oxygen use. This will result in a decreased level of care for oxygen patients, and will potentially greatly increase the incidence of emergency room visits. After the 9.5% Medicare reimbursement cuts for home oxygen suppliers goes into effect on January 1, 2009, a one-day hospital stay will cost more than it would cost to continue to provide home oxygen service for two years.

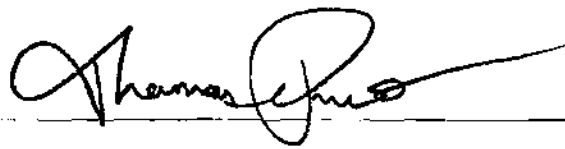
Home oxygen suppliers are more than just equipment suppliers, they are also caregivers. They show patients how to use their equipment, answer patients' questions, make repairs and adjustments, and ensure that patients are receiving the correct amount of oxygen. Many suppliers provide 24/7 unscheduled, emergency care, and in rural areas drive significant distances to make sure that their patients receive the care they need. Without reimbursements for these visits, suppliers may not be able to afford to continue their current level of care, and the quality of care for many of these oxygen patients is going to decrease.

Thank you for your consideration of our request to delay this rule.

Sincerely,



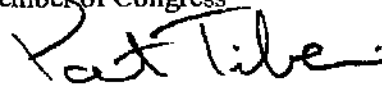
Heath Shuler
Member of Congress



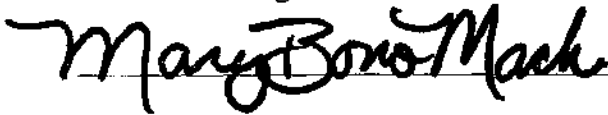
Tom Price, M.D.
Member of Congress



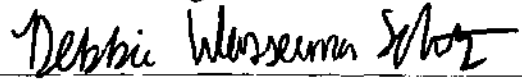
James Langevin
Member of Congress



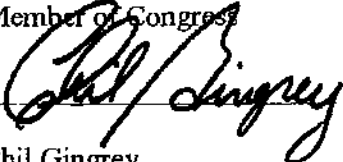
Patrick Tiberi
Member of Congress



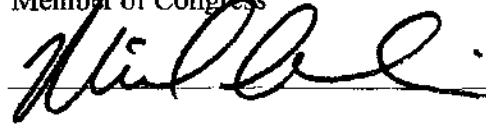
Mary Bono Mack
Member of Congress



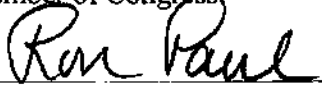
Debbie Wasserman Schultz
Member of Congress



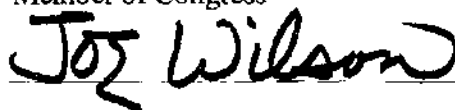
Phil Gingrey
Member of Congress



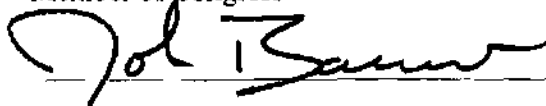
Michael A. Arcuri
Member of Congress



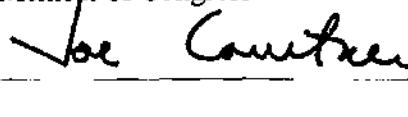
Ron Paul
Member of Congress



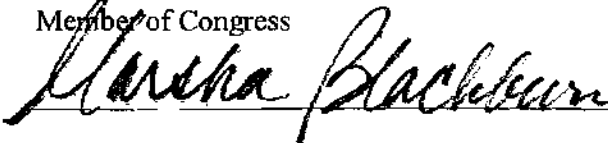
Joe Wilson
Member of Congress



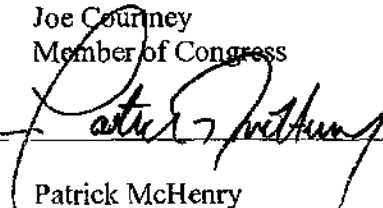
John Barrow
Member of Congress



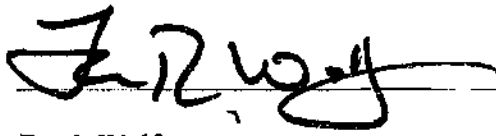
Joe Courtney
Member of Congress



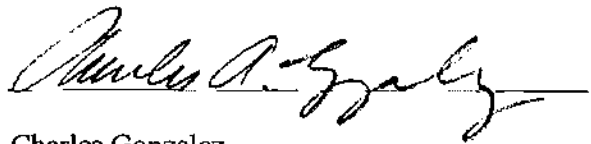
Marsha Blackburn
Member of Congress



Patrick McHenry
Member of Congress



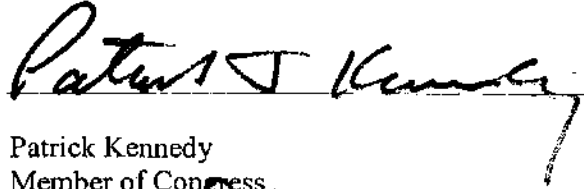
Frank Wolf
Member of Congress



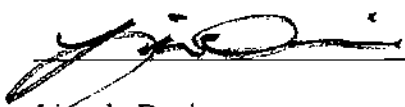
Charles Gonzalez
Member of Congress



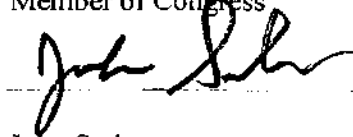
Shelley Berkley
Member of Congress



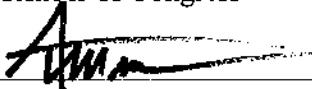
Patrick Kennedy
Member of Congress



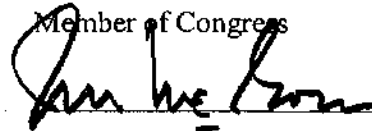
Lincoln Davis
Member of Congress



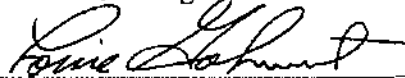
John Sarbanes
Member of Congress



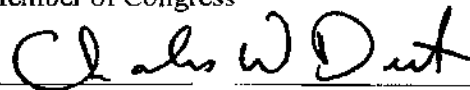
Ted Poe
Member of Congress



James P. McGovern
Member of Congress



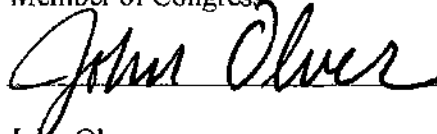
Louie Gohmert
Member of Congress



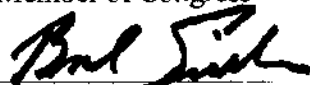
Charles Dent
Member of Congress



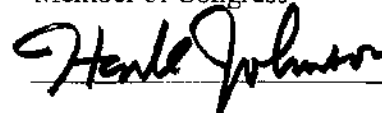
Mark Kirk
Member of Congress



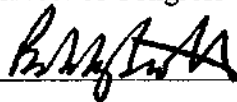
John Olver
Member of Congress



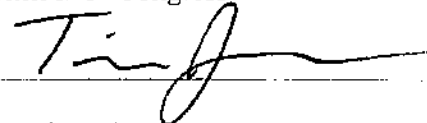
Brad Miller
Member of Congress



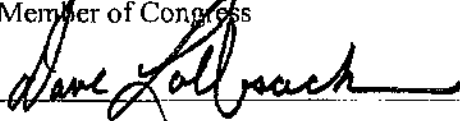
Henry C. "Hank" Johnson
Member of Congress



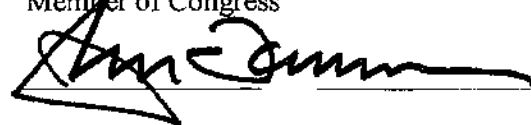
Robert C. "Bobby" Scott
Member of Congress



Timothy Johnson
Member of Congress



David Loeb sack
Member of Congress



John Tanner
Member of Congress

Steve Kagen, M.D.

Steve Kagen
Member of Congress

Paul Hodes
Member of Congress

Robert Wittman
Member of Congress

Bruce Braley
Member of Congress

Tim Ryan
Member of Congress

Robert Aderholt
Member of Congress

Zach Wamp
Member of Congress

John Boozman
Member of Congress

Mazie Hirono
Member of Congress

Michael Conaway
Member of Congress

Bob Etheridge
Member of Congress

Jeff Fortenberry
Member of Congress

Betty Sutton
Member of Congress

Michael Michaud
Member of Congress

Dennis Moore
Member of Congress

Michael Turner
Member of Congress

Dale Kildee
Member of Congress

Don Young
Member of Congress

Jerry Lewis
Member of Congress

Rick Boucher
Member of Congress

Paul P. Kanjorski

Paul Kanjorski
Member of Congress

Jerry Moran

Jerry Moran
Member of Congress

Pete Sessions

Pete Sessions
Member of Congress

Jo Bonner

Jo Bonner
Member of Congress

John F. Tierney

John Tierney
Member of Congress

James Moran

James Moran
Member of Congress

Lincoln Diaz-Balart

Lincoln Diaz-Balart
Member of Congress

Barney Frank

Barney Frank
Member of Congress

Peter Visclosky

Peter Visclosky
Member of Congress

Lynn Woolsey

Lynn Woolsey
Member of Congress

Steve Rothman

Steve Rothman
Member of Congress

Marion Berry

Marion Berry
Member of Congress

Nick Rahall

Nick Rahall
Member of Congress

Donald M. Payne

Donald Payne
Member of Congress

Walter B. Jones

Walter Jones
Member of Congress

Corrine Brown

Corrine Brown
Member of Congress

Alice Hastings

Alice Hastings
Member of Congress

James Oberstar

James Oberstar
Member of Congress

John McHugh

John McHugh
Member of Congress

Steven LaTourette

Steven LaTourette
Member of Congress

Chris Smith

Chris Smith
Member of Congress

Ralph M. Hall

Ralph Hall
Member of Congress

Ed Whitfield

Ed Whitfield
Member of Congress

Tim Holden

Tim Holden
Member of Congress

Frank LoBiondo

Frank LoBiondo
Member of Congress

Sanford D. Bishop

Sanford Bishop
Member of Congress

Maurice Hinchey

Maurice Hinchey
Member of Congress

Mike Ross

Mike Ross
Member of Congress

Mike McIntyre

Mike McIntyre
Member of Congress

Jo Ann Emerson

Jo Ann Emerson
Member of Congress

Todd Tiahrt

Todd Tiahrt
Member of Congress

Tammy Baldwin

Tammy Baldwin
Member of Congress

William Delahunt

William Delahunt
Member of Congress

Ellen Tauscher

Ellen Tauscher
Member of Congress

Howard Coble

Howard Coble
Member of Congress

Howard P. "Buck" McKeon

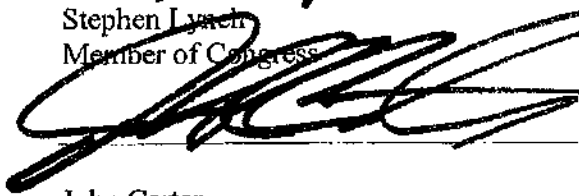
Howard P. "Buck" McKeon
Member of Congress



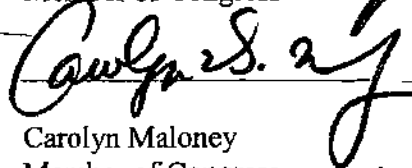
Stephen Lynch
Member of Congress



David Obey
Member of Congress



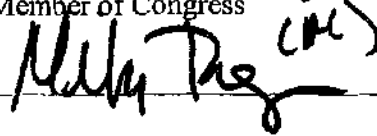
John Carter
Member of Congress



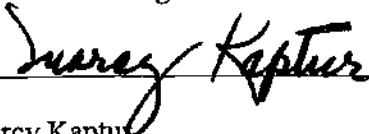
Carolyn Maloney
Member of Congress



John Lewis
Member of Congress



Mike Rogers
Member of Congress



Marcy Kaptur
Member of Congress



Tom Allen
Member of Congress



Ron Klein
Member of Congress



Artur Davis
Member of Congress



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stivers:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

Novocure requested a meeting with the Center for Clinical Standards and Quality. We are awaiting a final meeting date from Novocure. During that meeting, we expect Novocure to present all of the evidence, including any newly developed evidence that supports NovoTTF Therapy.

We appreciate your interest in this important technology. This response will also be shared with the cosigners of your letter. Please do not hesitate contacting me with any further thoughts or concerns.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner". The signature is written in black ink and is positioned above the printed name.

Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Gregg Harper
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harper:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

Novocure requested a meeting with the Center for Clinical Standards and Quality. We are awaiting a final meeting date from Novocure. During that meeting, we expect Novocure to present all of the evidence, including any newly developed evidence that supports NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Stephen Fincher
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fincher:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Tim Murphy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Murphy:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable David P. Joyce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Joyce:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Andy Harris
U.S. House of Representatives
Washington, DC 20515

Dear Representative Harris:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Joe Kennedy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kennedy:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Pete Sessions
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sessions:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

Novocure requested a meeting with the Center for Clinical Standards and Quality. We are awaiting a final meeting date from Novocure. During that meeting, we expect Novocure to present all of the evidence, including any newly developed evidence that supports NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Michael H. Michaud
U.S. House of Representatives
Washington, DC 20515

Dear Representative Michaud:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

Novocure requested a meeting with the Center for Clinical Standards and Quality. We are awaiting a final meeting date from Novocure. During that meeting, we expect Novocure to present all of the evidence, including any newly developed evidence that supports NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Devin Nunes
U.S. House of Representatives
Washington, DC 20515

Dear Representative Nunes:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Patrick J. Tiberi
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tiberi:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Joe Barton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barton:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Lamar Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Todd Young
U.S. House of Representatives
Washington, DC 20515

Dear Representative Young:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Ann Wagner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wagner:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Andre Carson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Carson:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Mark Amodei
U.S. House of Representatives
Washington, DC 20515

Dear Representative Amodei:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Shelly Moore Capito
U.S. House of Representatives
Washington, DC 20515

Dear Representative Moore Capito:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Tim Griffin
U.S. House of Representatives
Washington, DC 20515

Dear Representative Griffin:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Blaine Luetkemeyer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Luetkemeyer:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Chuck Fleischmann
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fleischmann:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Bob Gibbs
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gibbs:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Tom Reed
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reed:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Cathy McMorris Rodgers
U.S. House of Representatives
Washington, DC 20515

Dear Representative McMorris Rodgers:

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Gus Bilirakis
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Doug Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Michael Grimm
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grimm:

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Sincerely,

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Larry Bucshon
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bucshon:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Marilyn Tavenner



Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Luke Messer
U.S. House of Representatives
Washington, DC 20515

Dear Representative Messer:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Greg Walden
U.S. House of Representatives
Washington, DC 20515

Dear Representative Walden:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Katherine Clark
U.S. House of Representatives
Washington, DC 20515

Dear Representative Clark:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Robert E. Latta
U.S. House of Representatives
Washington, DC 20515

Dear Representative Latta:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Stephen F. Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Jim Renacci
U.S. House of Representatives
Washington, DC 20515

Dear Representative Renacci:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Tom Cole
U.S. House of Representatives
Washington, DC 20515

Dear Representative Cole:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Jeff Miller
U.S. House of Representatives
Washington, DC 20515

Dear Representative Miller:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Lee Terry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Terry:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Keith Rothfus
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rothfus:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Aaron Schock
U.S. House of Representatives
Washington, DC 20515

Dear Representative Schock:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Richard E. Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Tom Price
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Kerry Bentivolio
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bentivolio:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Jeff Fortenberry
U.S. House of Representatives
Washington, DC 20515

Dear Representative Fortenberry:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Steve Southerland, II
U.S. House of Representatives
Washington, DC 20515

Dear Representative Southerland, II:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Michael Turner
U.S. House of Representatives
Washington, DC 20515

Dear Representative Turner:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Ann McLane Kuster
U.S. House of Representatives
Washington, DC 20515

Dear Representative McLane Kuster:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Joyce Beatty
U.S. House of Representatives
Washington, DC 20515

Dear Representative Beatty:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Renee Ellmers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Ellmers:

Thank you for your letter, in which you discuss the treatment of glioblastoma brain tumors (GBM) and specifically the use of NovoTTF Therapy.

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Niki Tsongas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tsongas:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Diane Black
U.S. House of Representatives
Washington, DC 20515

Dear Representative Black:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Carol Shea-Porter
U.S. House of Representatives
Washington, DC 20515

Dear Representative Shea-Porter:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable John K. Delaney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Delaney:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Bill Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Johnson:

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Administrator
Washington, DC 20201

FEB 12 2015

The Honorable Scott Tipton
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tipton:

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Marilyn Tavenner

Congress of the United States

Washington, DC 20515

RECEIVED

DEC 23 2014

OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

December 15, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Dear Administrator Tavenner,

We are writing to you regarding an important development in the treatment of glioblastoma brain tumors (GBM), and specifically in the use of NovoTTF Therapy, an FDA approved therapy for the 2nd line treatment of GBM.

The FDA recently reviewed new results from a randomized and controlled pivotal trial that studied use of this therapy for 1st line treatment of GBM. The trial was stopped early because the interim analysis of the results indicated that adding NovoTTF Therapy to chemotherapy significantly extends survival for patients. As a consequence, FDA has approved allowing all patients treated in the control arm of the trial to crossover and receive treatment with NovoTTF Therapy.

As a reminder, decisions by the Centers for Medicare and Medicaid Services (CMS) and its local durable medical equipment administrative contractors (DME MACs) currently prevent Medicare beneficiaries from accessing NovoTTF Therapy. Given the aggressive and terminal nature of this disease, we ask that CMS and the DME MACs initiate a coordinated review of their existing decisions relating to both coverage and appropriate payment for NovoTTF Therapy in light of this important new clinical data.

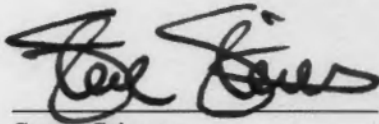
Glioblastoma (GBM) is the most common and deadly form of primary brain tumor, affecting approximately 10,000 people each year in the United States. The disease is broadly distributed in the population; by statistical probability every Congressional district will have between 20 to 30 people diagnosed with GBM each year. This disease is aggressive and we want to ensure our constituents have appropriate access to proven therapies. The available data shows that NovoTTF Therapy will extend the lives of GBM patients.

We note that NovoTTF Therapy is a home use therapy that shifts cancer care away from the hospital. NovoTTF Therapy seems consistent with Medicare's mission to provide beneficiaries with access to quality care while promoting innovation that can lower the cost of care, in this case by shifting treatments to the home setting and away from the hospital setting.

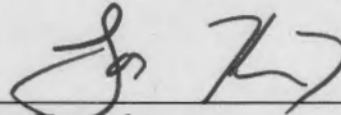
We respectfully request that CMS and the DME MACs, within the scope of existing laws, regulations and rules, reconsider any policies or determinations that would limit beneficiary access to this therapy and that your groups coordinate the review to ensure an expedited and concurrent rather than sequential review of policies and determinations. We also ask that CMS provide us with an update after its review of the matter.

Thank you in advance for consideration. If you have any questions, comments or concerns, please feel free to contact Sarah Curtis in Congressman Kennedy's office at 202-225-5931 or Taryn Dorfman in Congressman Stivers' office at (202) 225-2015.

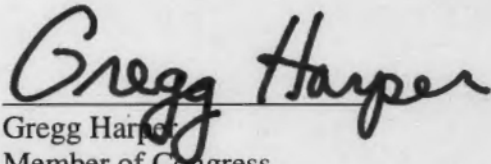
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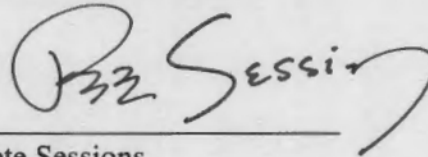
Steve Stivers
Member of Congress



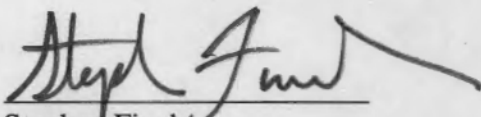
Joe Kennedy
Member of Congress



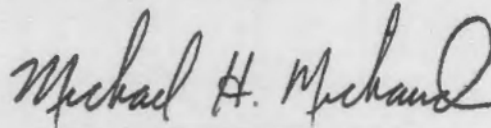
Gregg Harper
Member of Congress



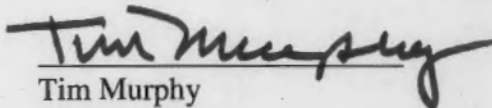
Pete Sessions
Member of Congress



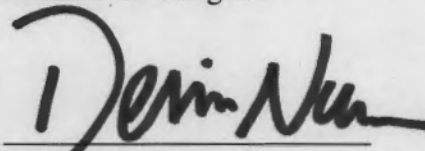
Stephen Fincher
Member of Congress



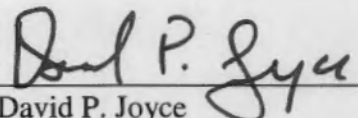
Michael H. Michaud
Member of Congress



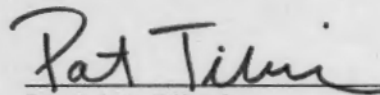
Tim Murphy
Member of Congress



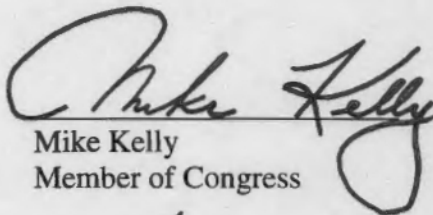
Devin Nunes
Member of Congress



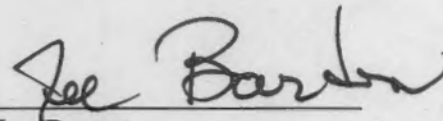
David P. Joyce
Member of Congress



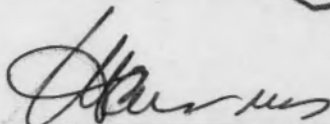
Patrick J. Tiberi
Member of Congress



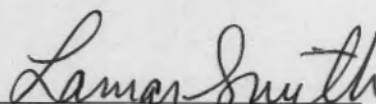
Mike Kelly
Member of Congress



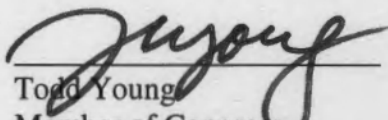
Joe Barton
Member of Congress

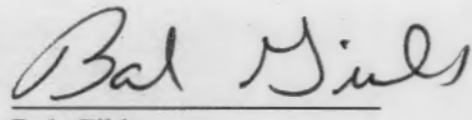


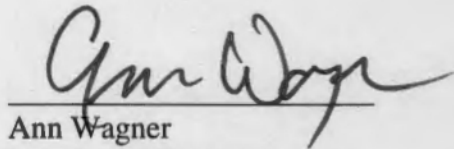
Andy Harris
Member of Congress

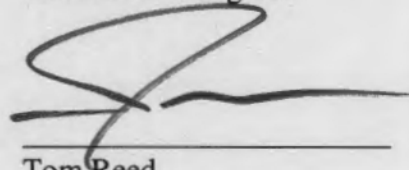


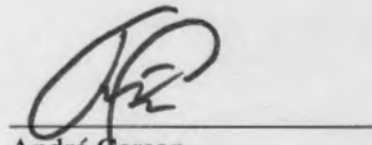
Lamar Smith
Member of Congress

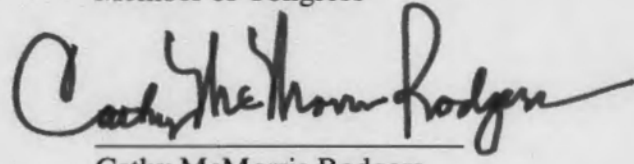

Todd Young
Member of Congress

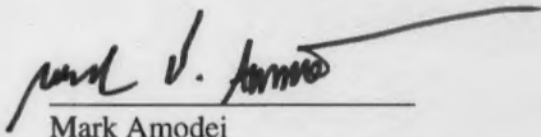

Bob Gibbs
Member of Congress

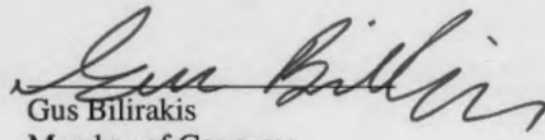

Ann Wagner
Member of Congress

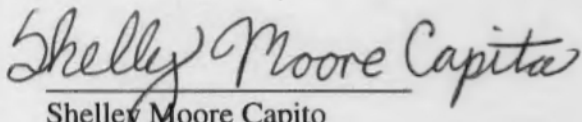

Tom Reed
Member of Congress

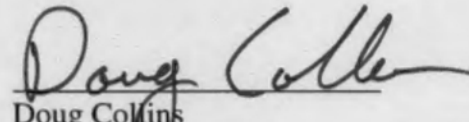

André Carson
Member of Congress

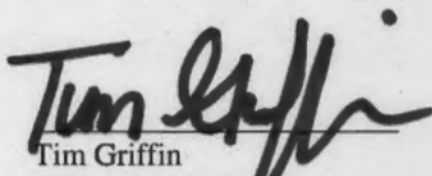

Cathy McMorris Rodgers
Member of Congress

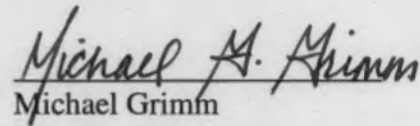

Mark Amodei
Member of Congress

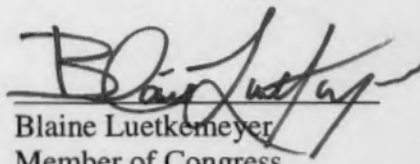

Gus Bilirakis
Member of Congress

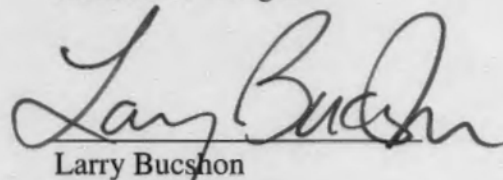

Shelley Moore Capito
Member of Congress

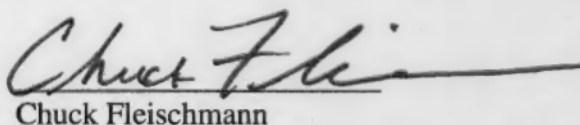

Doug Collins
Member of Congress

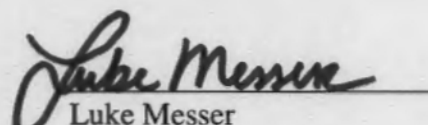

Tim Griffin
Member of Congress

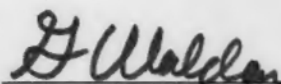

Michael Grimm
Member of Congress


Blaine Luetkemeyer
Member of Congress

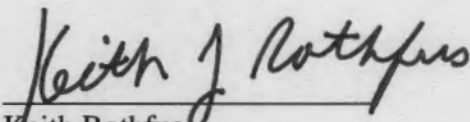

Larry Bucshon
Member of Congress


Chuck Fleischmann
Member of Congress

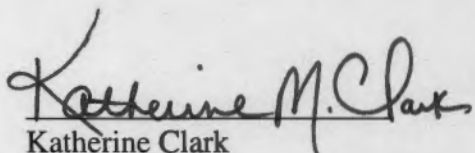

Luke Messer
Member of Congress



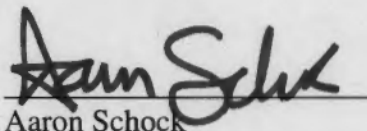
Greg Walden
Member of Congress



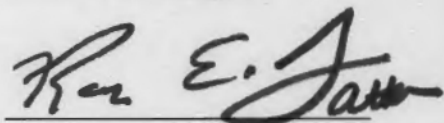
Keith Rothfus
Member of Congress



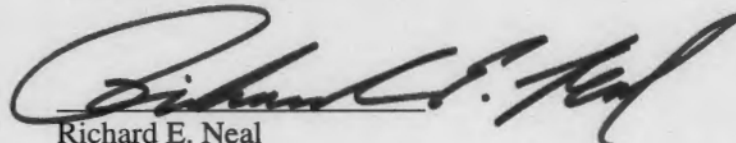
Katherine Clark
Member of Congress



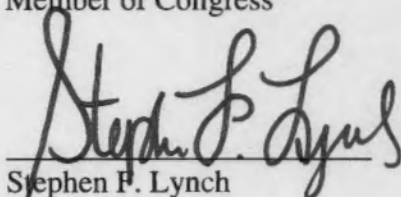
Aaron Schock
Member of Congress



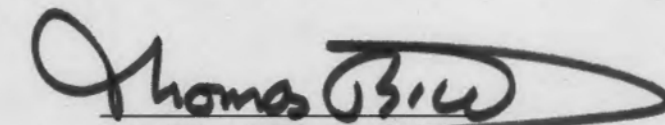
Robert E. Latta
Member of Congress



Richard E. Neal
Member of Congress



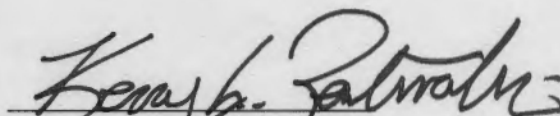
Stephen F. Lynch
Member of Congress



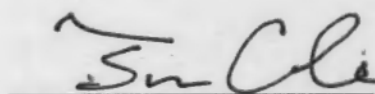
Tom Price, MD
Member of Congress



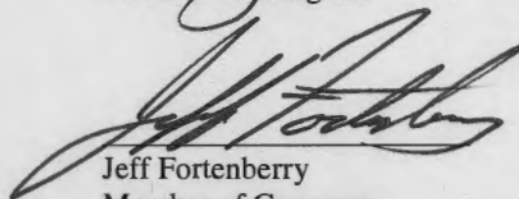
Jim Renacci
Member of Congress



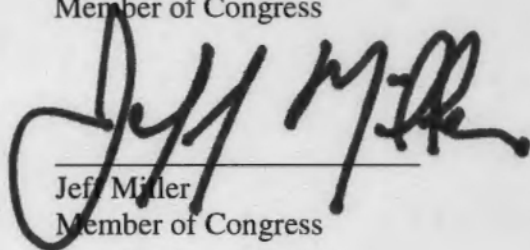
Kerry Bentivolio
Member of Congress



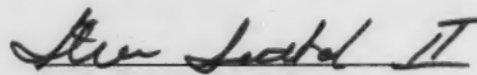
Tom Cole
Member of Congress



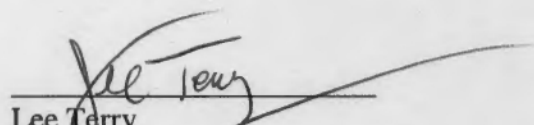
Jeff Fortenberry
Member of Congress



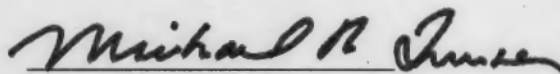
Jeff Miller
Member of Congress



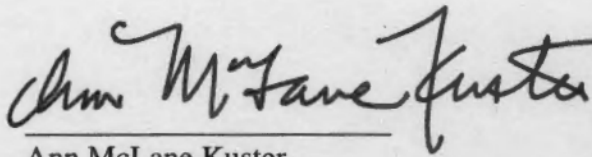
Steve Southerland, II
Member of Congress



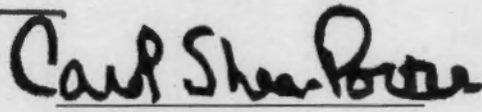
Lee Terry
Member of Congress



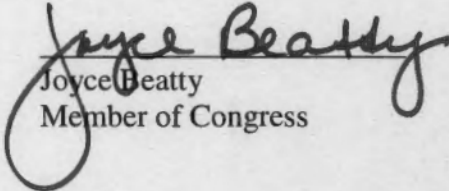
Michael Turner
Member of Congress




Ann McLane Kuster
Member of Congress



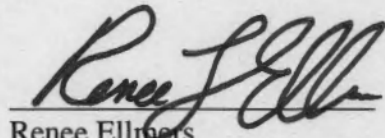
Carol Shea-Porter
Member of Congress



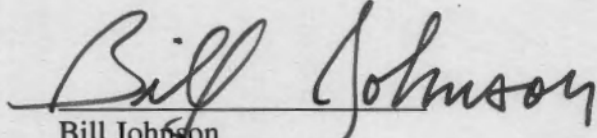
Joyce Beatty
Member of Congress



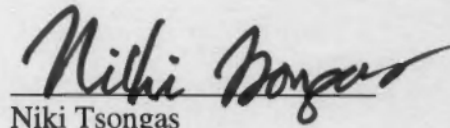
John K. Delaney
Member of Congress



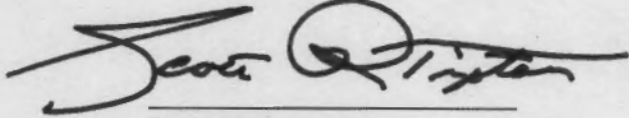
Renee Ellmers
Member of Congress



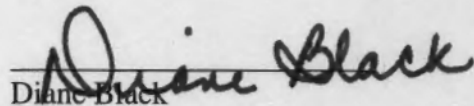
Bill Johnson
Member of Congress



Niki Tsongas
Member of Congress



Scott Tipton
Member of Congress



Diane Black
Member of Congress



APR - 1 2016

Administrator

Washington, DC 20201

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding Medicare coverage, coding, and payment for ventilators. The Centers for Medicare & Medicaid Services (CMS) appreciates your bringing these concerns to our attention.

Medicare policy regarding payment for ventilators is governed by section 1834(a)(3) of the Social Security Act, which provides for payment on a continuous monthly rental basis for ventilators and other equipment requiring frequent and substantial servicing in order to avoid risk to the patient. This section mandates that the Medicare fee schedule amounts for ventilators be based on the average reasonable charge for rental of the item from July 1, 1986, through June 30, 1987, increased by annual covered item update factors.

Effective January 1, 2016, separate Healthcare Common Procedure Coding System (HCPCS) codes for ventilators are consolidated to establish one uniform payment rate for all ventilators based on the monthly rental fee schedule amounts mandated by the statute for use in paying claims for ventilators. New codes for certain ventilators were added to the HCPCS in 2003 and 2005 based on a request stating that the ventilators described by the codes would be used only for pediatric patients or patients being weaned off ventilators. However, CMS has determined that there is no program need to have separate HCPCS codes for different types of ventilators. The Medicare coverage rules for ventilators are the same regardless of what type of ventilator is used. Consolidating the HCPCS codes for ventilators is also necessary to be in compliance with the applicable statutory payment rule.

The actions to add codes E0463 and E0464 to the HCPCS in 2005 were made through the process for modifying the HCPCS described at the following website:
<https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSCODINGPROCESS.html>.
The actions to discontinue codes E0463 and E0464 likewise were made through this process. We do not believe these coding actions place any beneficiaries at risk. However, we are closely monitoring 2016 claims data for ventilators compared to claims processed for these items at the same time in 2015. For claims processed through March 15, 2015, Medicare allowed 18,262 monthly rental services for 17,329 beneficiaries using ventilators. For claims processed through March 15, 2016, Medicare allowed 22,236 monthly rental services for 21,421 beneficiaries using

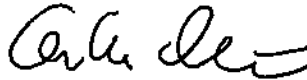
Page 2 – The Honorable Tom Price, M.D.

ventilators. The bulk of these claims are for dates of service in January of each respective year. As was the case in 2015, suppliers are accepting assignment of all claims for ventilators in 2016. We will continue to closely monitor the 2016 claims data compared to 2015 data.

Regarding your concern about regional variation in local coverage determinations (LCDs), the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) are required by their Statement of Work to have identical LCDs, unlike other MACs whose coverage may vary by region. Thus, for DME, there is no regional variation in coverage.

I appreciate your interest in this important issue as we work towards ensuring accurate payments and access to these devices and other DME for our beneficiaries. Please do not hesitate to contact me if you have any further thoughts or concerns. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt", with a stylized flourish at the end.

Andrew M. Slavitt
Acting Administrator

CHARLES W. BOUSTANY, JR., MD
3RD DISTRICT, LOUISIANA

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEES:
CHAIRMAN ON OVERSIGHT
TRADE
HUMAN RESOURCES



Congress of the United States
House of Representatives
Washington, DC 20515-1803

December 18, 2015

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1431 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2031

LAFAYETTE DISTRICT OFFICE:
800 LAFAYETTE STREET
SUITE 1400
LAFAYETTE, LA 70501
(337) 235-6322

LAKE CHARLES DISTRICT OFFICE:
ONE LAKESHORE DRIVE
SUITE 1775
LAKE CHARLES, LA 70629
(337) 433-1747

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Dear Administrator Slavitt:

We write to express serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) plan to implement a 35% cut in Medicare payments for ventilator services (E0464 and E0463), and to urge you to delay these cuts.

You note that these cuts are necessary to address the increases in the number of patients using ventilators. While it might be appropriate to address an increase in the "ventilator use," simply cutting payments does not distinguish between patients needing ventilators to survive and patients able to utilize other devices. The reduction in Medicare payment places some of the most critically ill beneficiaries at serious risk; for example, patients with amyotrophic lateral sclerosis (ALS) or chronic obstructive pulmonary disease (COPD) often need to use ventilators just to stay alive.

I also understand that CMS did not provide a real opportunity for patients, physicians and others to provide meaningful input that could subsequently be taken into consideration by CMS through the traditional regulatory notice and comment period.

CMS sought comment on the decision to cut payments by providing notice through a "web link" in a Medicare contractor-specific announcement. While patient advocates and providers are alert and follow proposed regulations, using an obscure web-link location to make this announcement disenfranchised patients, their advocates and providers. We would like to believe that your agency would make widely available for public comment any proposal that stands to negatively impact the lives of so many patients.

Moreover, this change in payments also seems counter-intuitive to the need for more efficient use of Medicare dollars wherever it can be achieved; the critical improvements in home ventilator technology poses an opportunity to bring substantial cost savings to the Medicare program. More specifically, today's home ventilators are very similar to the equipment available in hospitals, enabling many patients to now receive this care at home rather than at a more expensive hospital or other type of inpatient setting. Physician can

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Done - 1/13/16

prescribe home ventilators knowing that their patients can safely receive care at home instead of a hospital. This has resulted in substantial savings for the Medicare program.

We also understand that each regional Medicare Administrative Contractor (MAC) has different criteria and standards for determining the "medical necessity" of ventilator services. When reviewing the records of the same patient, a MAC in one region would find ventilator services medically necessary while a MAC in another region would find the use of the same service medically unnecessary.

For these reasons, we urge you to delay the reduction in Medicare payments for ventilator services for one year, affording CMS the ample time needed to thoughtfully consider all aspects and relevant input critical to ensuring the efficacy of such a policy change. Finally, in addition to thoughtful reconsideration of the change in payments, we strongly urge CMS to develop consistent and appropriate standards and criteria to clearly guide decision-makers on the appropriate use of ventilator services.

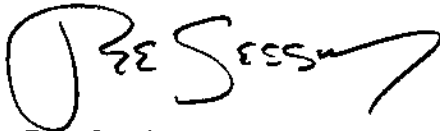
Sincerely,



Charles W. Boustany, Jr., M.D.
Member of Congress



Tom Price, M.D.
Member of Congress



Pete Sessions
Member of Congress



Devin Nunes
Member of Congress



Jim Renacci
Member of Congress



Robert Dold
Member of Congress

CPM

Chris Gibson
Member of Congress

SH-16

George Holding
Member of Congress

Pat Tiberi

Pat Tiberi
Member of Congress

Marsha Blackburn

Marsha Blackburn
Member of Congress

David Joyce

David P. Joyce
Member of Congress

Tim Murphy

Tim Murphy
Member of Congress

Scott DeJarlais

Scott DeJarlais, M.D.
Member of Congress

Diane Black

Diane Black
Member of Congress

Mike Kelly

Mike Kelly
Member of Congress

Doug Collins

Doug Collins
Member of Congress

Lou Barletta

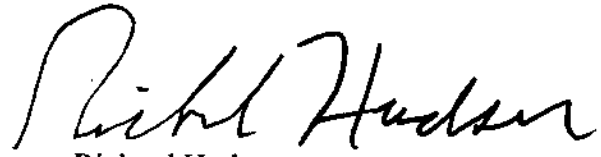
Lou Barletta
Member of Congress

Renee Ellmers

Renee Ellmers
Member of Congress



Michael R. Turner
Member of Congress



Richard Hudson
Member of Congress



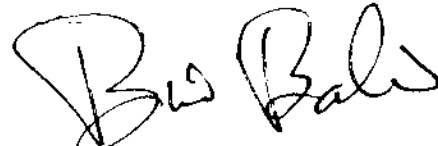
Pete Olson
Member of Congress



Andy Barr
Member of Congress



Keith Rothfus
Member of Congress



Brian Babin
Member of Congress



Gus Bilirakis
Member of Congress

Congress of the United States
Washington, DC 20515

June 29, 2015

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 416 G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

As medical providers and elected representatives, the GOP Doctors Caucus would like to share our serious concerns with the recently proposed U.S. Preventive Services Task Force (USPSTF) breast cancer screening recommendations.

We disagree with the Affordable Care Act's policy of tying preventative service coverage requirements to USPSTF recommendations. But because it is the law, the "C" grade the USPSTF assigned to screening mammograms for women between the ages of 40 and 49 will limit access to this valuable diagnostic tool for 17 million women. These draft recommendations are not only inconsistent with current clinical practice, but could also result in thousands of additional breast cancer deaths if followed.

We believe that patients and the medical providers with whom they have an established relationship—who themselves follow clinical guidelines developed by their specialty societies—should decide which diagnostic tools are most appropriate in a given case. We would also remind the USPSTF and other stakeholders to keep in mind that patients are not study subjects, but human beings. For a woman stricken with breast cancer, the incidence of disease is 100 percent. Should the USPSTF recommendations become finalized, they will have a chilling effect on coverage for diagnostic mammograms, jeopardizing the health of American women.

We urge you do everything in your power to ensure that these draft recommendations are not finalized so that women are not confused about the role of screening, and so that access is preserved to the best screening tools available when a patient and her medical providers decide a mammogram is necessary.

Sincerely,

David P. Rice

CW Banker

John Fleming

Harold A. ...

Fred R. Waring

Quinn Black

Thomas Price

John TN-04

Joe Heck

Kenneth Ellis

Larry Burt

John

Benjamin

Don Smith