



APR 21 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 potential impact of our regulation, CMS-6036-F, "Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards" on existing consignment closet arrangements. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

Consignment closet arrangements involve a physician, or other provider, giving patients supplies at the physician's or provider's location without requiring ownership of the supplies. These arrangements have not been affected by the new regulation, and are not expressly prohibited, provided such arrangements comply with the DMEPOS supplier standards, as well as applicable Medicare laws, rules, and regulations. We will provide clarifying guidance through the Web site of our DMEPOS enrollment contractor, the National Supplier Clearinghouse. This guidance will confirm that nothing in the aforementioned regulation prevents DMEPOS suppliers from entering into consignment closet arrangements that comply with applicable Medicare laws, rules, and regulations.

I appreciate your interest in these important issues as we work towards our mutual goal of strengthening the Medicare program. Should you have questions or wish to discuss our policy, please do not hesitate to contact me. Should members of your staff have questions, they may contact our Office of Legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Berwick", written over a horizontal line.

Donald M. Berwick, M.D.

**TOM PRICE, M.D.**  
5TH DISTRICT, GEORGIA

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**Congress of the United States**  
**House of Representatives**

December 2, 2010

COMMITTEE ON  
FINANCIAL SERVICES  
SUBCOMMITTEES:  
CAPITAL MARKETS  
DEPUTY BANKING MEMBER  
DOMESTIC MONETARY POLICY AND  
TECHNOLOGY  
FINANCIAL INSTITUTIONS AND  
CONSUMER CREDIT  
  
COMMITTEE ON  
EDUCATION AND LABOR  
SUBCOMMITTEES:  
WORKFORCE PROTECTION  
HEALTH, EMPLOYMENT, LABOR AND PENSIONS  
BANKING MEMBER  
  
REPUBLICAN STUDY COMMITTEE  
CHAIRMAN

DEPUTY WHIP

Dr. Donald Berwick  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244

RECEIVED

JAN - 7 2011

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

Dear Dr. Berwick:

As an orthopaedic surgeon with over two decades of practice experience, I have a personal and strong interest in government policies impacting patient access to care. Consequently, I am writing you in an effort to obtain written clarity about a sweeping new regulation impacting home medical equipment suppliers, physicians, and the patients they serve.

On August 27, 2010, CMS published in the Federal Register a final rule establishing additional standards that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must meet in order to receive reimbursement from the Medicare program. Many of the standards are new and substantive in nature, and it has come to my attention that there has been significant confusion by many physicians about the impact of these changes on so-called "consignment closets."

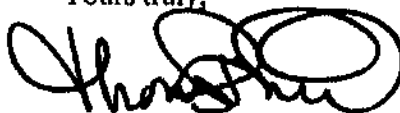
For example, there is a question as to whether the new rule prohibits a DMEPOS supplier from sharing a practice location with another Medicare supplier. I have been encouraged in recent weeks by discussions between CMS officials and Congressional staff that these new regulations would not impact so-called consignment closets. However, the language contained within the rule is at best unclear, and unless clarified in writing could lead some physicians and suppliers to suspend their current practice of utilizing these closets. During my days in practice, the use of consignment closets were most beneficial to my patients. If these become prohibitive, either by cost or regulatory nuisance, many Medicare patients will not be able to receive the vital care necessary in the most cost effective, efficient, and safe manner. Requiring patients to take a doctor's prescription for a particular device, leave the office without the medically necessary product, and seek a vendor, exposes patients to unreasonable burden and increased risk. Essentially, we would have a situation where Medicare patients are receiving a significantly lower and more burdensome level of care from patients receiving care through a private insurer.

We should not unnecessarily create obstacles to timely beneficiary access to medically necessary products. A rule that is generating this level of inquiry, and that leaves so many questions



unanswered, demands that CMS provide written clarification and direction for physicians, patients and suppliers. Thank you for your prompt consideration and I look forward to your clarifying response.

Yours truly,

A handwritten signature in black ink, appearing to read 'Tom Price', with a large, stylized flourish at the end.

Tom Price, M.D.  
Member of Congress

**Congress of the United States**  
**Washington, DC 20515**

December 11, 2008

RECEIVED

JAN 21 2009

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

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. If you have any questions, please contact Erin Doty in Congressman Shuler's office at [erin.doty@mail.house.gov](mailto:erin.doty@mail.house.gov) (225-6401) or Emily Henehan in Congressman Tom Price's office at [emily.henehan@mail.house.gov](mailto:emily.henehan@mail.house.gov) (225-4501).

Sincerely,

Mae White



MAR - 2 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 a December 11, 2015 National Supplier Clearinghouse (NSC) announcement pertaining to Medicare policy on consignment closets. You expressed concern that the announcement, which was issued to clarify the Centers for Medicare & Medicaid Services' (CMS) policy on consignment closet arrangements, barred common arrangements through which orthotics specialists help physicians and hospitals furnish the most appropriate braces and other orthotics to their Medicare patients, and that this would impede patient access to medically necessary items.

After receiving many questions and comments from the supplier community regarding the clarification, on January 26, 2016, CMS instructed the NSC to remove the clarification from its website. The NSC did so on January 29, 2016, and the policy is no longer in effect. No claim payments should be impacted as a result of the policy clarification and subsequent removal. CMS is reevaluating this matter and will issue further guidance as needed.

Thank you again for taking the time to write me on this important issue. I look forward to working with you as we continue safeguarding Medicare beneficiaries' access to high-quality durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS), while also combatting and reducing fraud, waste, and abuse associated with DMEPOS.

Sincerely,

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

Andrew M. Slavitt  
Acting Administrator

**TOM PRICE, M.D.**  
8TH DISTRICT, GEORGIA

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COMMITTEE ON THE BUDGET  
CHAIRMAN

COMMITTEE ON WAYS AND MEANS

**Congress of the United States**  
**House of Representatives**

February 8<sup>th</sup>, 2016

Mr. Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Slavitt:

I am writing in response to a December 11, 2015 National Supplier Clearinghouse (NSC) announcement pertaining to Medicare policy on "consignment closets." This policy change is another example of CMS' failure to recognize the reality faced by patients and their physicians and thereby disrupt patient care.

Consignment closet arrangements have long been used by physician offices and hospitals in outpatient settings as a convenient way to ensure that their patients can expeditiously receive needed durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) without the physician or hospital having to enroll as Medicare suppliers. For instance, a patient who seeks treatment from a physician for a foot fracture can receive the appropriate walking boot on the spot from an orthotics specialist working on behalf of an accredited orthotics supplier, without the injured beneficiary needing to travel to find a Medicare-participating supplier and without the physician having to go through the rigorous and expensive process of becoming a Medicare DMEPOS supplier.

According to the new NSC announcement, CMS has recently released clarification of the rules for the use of consignment closets. Although no new CMS policy is actually cited and we are unable to identify any such recent release, the NSC states that in order for a DMEPOS supplier to bill for items furnished through a consignment closet arrangement, "the DMEPOS supplier cannot be present or perform any functions at the medical provider/supplier facility." This significant change bars common arrangements through which orthotics specialists help physicians and hospitals furnish the most appropriate braces and other orthotics to their Medicare patients. If this policy stands, it will impede patient access to medically necessary items.

It is very alarming that this CMS/NSC policy appears to have been issued without any public notice or comment opportunity, despite the significant impact this policy would have on suppliers and providers. It also appears to be effective immediately, which creates immediate access issues for patients and disrupts physician practices.

Given the fact that there has been no appropriate notice to the medical community about potential changes to the consentment policy, I insist that CMS instruct the NSC to retract its new guidance. Instead, any changes by CMS to consentment policy should always be made through the regular notice and comment rulemaking process.

This new policy change will continue to put patients at risk with each passing day. I look forward to your prompt response with a resolution for this critically important issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas Price". The signature is written in a cursive style and is enclosed within a large, hand-drawn oval.

Tom Price, M.D.  
Member of Congress



APR 14 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 Local Coverage Determination (LCD) on Biomarkers in Cardiovascular Risk Assessment (DL36358) that is currently under review by multiple Medicare Administrative Contractors (MACs). The Centers for Medicare & Medicaid Services (CMS) greatly appreciates you bringing your concerns to our attention.

As you may be aware, CMS does not develop or implement LCDs. Rather, the MACs are authorized to develop LCDs in the absence of national policy or as long as those LCDs do not conflict with a national policy. MACs publish LCDs to provide guidance within their jurisdictions to assist providers in submitting proper claims for payment.

We do require, however, when developing LCDs, that the MACs follow the LCD development process established by CMS, including opportunities for public comment and input from the local medical community, as described in Chapter 13 of the CMS Medicare Program Integrity Manual, which is available at:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf>.

As part of that process, the MACs consider all comments received on a proposed LCD prior to developing and posting a final LCD. We have confirmed that your comments were received by the MACs involved in the development of this proposed policy for their consideration.

Thank you again for sharing your concerns and for your commitment to assuring access to innovative and value-based approaches to care for the Medicare population.

Sincerely,

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

Andrew M. Slavitt  
Acting Administrator

**TOM PRICE, M.D.**  
6TH DISTRICT, GEORGIA

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COMMITTEE ON THE BUDGET  
CHAIRMAN

COMMITTEE ON WAYS AND MEANS

## Congress of the United States House of Representatives

February 8<sup>th</sup>, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Acting Administrator Slavitt,

I am writing to express concern about the Local Coverage Determination (LCD) ModDX: Biomarkers in Cardiovascular Risk Assessment (DL36358), which is currently under review in numerous Medicare Administrative Contractor (MAC) jurisdictions. This policy would discontinue coverage for most cardiovascular risk assessment diagnostics. If finalized, this policy will deny physicians and Medicare beneficiaries access to life-saving cardiovascular risk assessment tools and raise costs for the Medicare program.

Often called the “silent killer,” cardiovascular disease is our nation’s leading cause of death. According to data from Johns Hopkins, 84 million people in the United States suffer from some form of cardiovascular disease, causing approximately 2,200 deaths a day, or one death every 40 seconds. One out of three deaths in the United States is the result of cardiovascular disease, and the direct and indirect costs of cardiovascular disease and stroke are about \$315 billion annually—a number that is increasing each year.<sup>1</sup>

Complicating the issue, the traditional indicators of cardiovascular disease risk, like the 50 year-old lipid panel, are now known to detect such risk in only a subset of patients. In fact, the majority of people who suffer heart attacks and stroke have “normal” lipid panel values. Fortunately, researchers and clinicians have developed additional diagnostic tests to much more accurately identify cardiovascular risk. For example, peer-reviewed research has demonstrated that the presence of atherogenic plaque is an indicator of cardiovascular disease.<sup>2,3</sup> For the

<sup>1</sup> *Cardiovascular Disease Statistics*, JOHNS HOPKINS MEDICINE, [http://www.hopkinsmedicine.org/healthlibrary/conditions/cardiovascular\\_diseases/cardiovascular\\_disease\\_statistics\\_85.P00243/](http://www.hopkinsmedicine.org/healthlibrary/conditions/cardiovascular_diseases/cardiovascular_disease_statistics_85.P00243/).

<sup>2</sup> Brillakis ES et al., *Association of Lp-PLA2 levels with coronary artery disease risk factors, angiographic coronary artery disease and major adverse events at follow-up*, EUROPEAN HEART JOURNAL (2005), <http://www.ncbi.nlm.nih.gov/pubmed/15618069>.

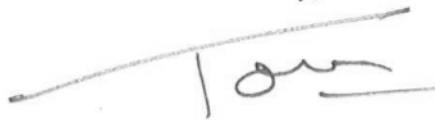


Medicare population with atherosclerosis, the correct diagnosis of an individual patient's disease etiology is essential for treatment directed towards the underlying disorder. Clinicians who have access to these diagnostic tools can develop a personalized healthcare plan for their patients, including modifications to diet, exercise, and medication.

Clinically-appropriate, physician-ordered testing for cardiovascular risk can also lead to lower costs for taxpayers. These tests typically cost between \$15 - \$45 dollars, much less than the cost of acute and post-acute care for patients who have a cardiac episode. Of note, an April 2015 study in the *Journal of Medical Economics* estimated that biomarker testing among a subgroup of health plan members 35 years old and older significantly reduced cardiac events, yielding a cost savings of \$187 million over 5 years for a patient population of one million members, or \$3.13 per member per month, excluding test costs.<sup>4</sup> The potential savings to the Medicare program, which has 54 million beneficiaries,<sup>5</sup> would amount to more than \$10 billion over 5 years.

To make health care for our seniors accessible and affordable, we must identify and foster innovative, value-based approaches to disease prevention and management. To the contrary, implementation of the proposed LCD would preclude Medicare beneficiaries in your jurisdiction from accessing this type of diagnostic testing. **I urge, therefore, that the proposed LCD DL36358 be retracted, and that the MACs engage with clinicians and researchers to better understand their perspectives on these life-saving tests and develop a clinically-appropriate policy.**

Sincerely,



Tom Price, M.D.

CC: Arthur Lurvey, MD, FACP, FACE, Medical Director, Noridian Healthcare Solutions, LLC.

Harry Feliciano, MD, MPH, Medical Director, Palmetto GBA

Earl Berman MD, FACP, Medical Director, CGS Administrators, LLC

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<sup>3</sup> Ballantyne CM et al., *Lp-PLA2, CRP and risk for incident ischemic stroke in middle aged men and women in the ARIC Study*, ARCHIVES OF INTERNAL MEDICINE (2005), <http://www.ncbi.nlm.nih.gov/pubmed/16314544>.

<sup>4</sup> M.S. Penn et al., *The Economic Impact of Implementing a Multiple Inflammatory Biomarker-based Approach to Identify, Treat, and Reduce Cardiovascular Risk*, JOURNAL OF MEDICAL ECONOMICS (April 1, 2015), <http://www.ncbi.nlm.nih.gov/pubmed/25763924>.

<sup>5</sup> *2014 CMS Statistics*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2014\\_final.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf).



MAY - 9 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 expressing concern with the National Correct Coding Initiative edits (NCCI) that result in denial of payment for Current Procedure Terminology (CPT) code 29823, arthroscopic shoulder debridement, extensive, when furnished in conjunction with several other arthroscopic shoulder procedures, such as CPT code 29827, arthroscopic rotator cuff repair or CPT code 29824, arthroscopic distal claviclectomy including distal articular surface. The Centers for Medicare & Medicaid Services (CMS) appreciates your interest on this issue.

Since you wrote, CMS officials, including medical officers, met again with representatives of American Academy of Orthopaedic Surgeons (AAOS) to discuss these edits. Following that meeting we informed the AAOS that we would be deleting the NCCI procedure-to-procedure edits for the code pairs 29824/29823, 29827/29823 and 29828/29823. These deletions will be effective in the July 1, 2016 version of NCCI. We have informed the AAOS of this decision.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries and assuring access to cancer care for our citizens. I will also provide this response to Senator John Barrasso.

Sincerely,

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

Andrew M. Slavitt  
Acting Administrator



MAY - 9 2016

*Administrator*  
Washington, DC 20201

The Honorable John Barrasso, M.D.  
United States Senate  
Washington, DC 20510

Dear Senator Barrasso:

Thank you for your letter expressing concern with the National Correct Coding Initiative edits (NCCI) that result in denial of payment for Current Procedure Terminology (CPT) code 29823, arthroscopic shoulder debridement, extensive, when furnished in conjunction with several other arthroscopic shoulder procedures, such as CPT code 29827, arthroscopic rotator cuff repair or CPT code 29824, arthroscopic distal claviclectomy including distal articular surface. The Centers for Medicare & Medicaid Services (CMS) appreciates your interest on this issue.

Since you wrote, CMS officials, including medical officers, met again with representatives of American Academy of Orthopaedic Surgeons (AAOS) to discuss these edits. Following that meeting we informed the AAOS that we would be deleting the NCCI procedure-to-procedure edits for the code pairs 29824/29823, 29827/29823 and 29828/29823. These deletions will be effective in the July 1, 2016 version of NCCI. We have informed the AAOS of this decision.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries and assuring access to cancer care for our citizens. I will also provide this response to Representative Tom Price.

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**

February 25, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201


Dear Acting Administrator Slavitt,

CMS relies on Correct Coding Initiative (CCI) software to issue and deny payments. Since 2013, edits made to CCI have bundled several codes together for shoulder surgery have resulted in denied payment when these procedures are performed together. Specifically, these edits have denied CPT code 29823, Arthroscopic Shoulder Debridement, extensive, with several other arthroscopic shoulder procedures such as CPT code 29827, Arthroscopic Rotator Cuff Repair, or CPT code 29824, Arthroscopic distal claviclectomy. These are distinctly separate procedures.

This issue is of extreme importance to the American Association of Orthopaedic Surgeons (AAOS), the American Orthopaedic Society for Sports Medicine (AOSSM), the Arthroscopy Association of North America (AANA), and the American Shoulder and Elbow Surgeons (ASES). The societies have written multiple letters to CMS and the third party that owns and implements the CCI software (called the National Correct Coding Initiative-NCCI) and held multiple conference calls and face-to-face meetings with CMS and NCCI, including a meeting at CMS headquarters in May 2015 with Marc Hartstein, Director of the Hospital and Ambulatory Policy Group, and other CMS officials. After the May 2015 meeting, several documents were submitted to CMS indicating the CCI edits the societies felt were erroneous along with materials describing anatomically why these edits were incorrect. CMS stated they would take the request under review to change their edits and the policy manual for January 1, 2016. These edits and policy manual were released recently and did not result in any correction to the policy or edits in question.

Earlier this year, the AAOS submitted a request to meet with you, personally, about this issue. However, we recently received news that the request was denied, and they were offered an opportunity to meet with the Deputy Director of the Center for Medicare. The AAOS has already discussed this issue with other members of the CMS and it is important that this issue be fully understood. Therefore, we are asking you to reconsider their request and would like to encourage you, personally, to orchestrate a meeting to discuss the shoulder coding issue.

Sincerely,



Tom Price, M.D.



John Barrasso, M.D.



MAY -6 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 Calendar Year (CY) 2017 Advance Notice and Draft Call Letter for Medicare Advantage. I appreciate your observations and concerns and agree that Medicare Advantage (MA) is a critical part of the Medicare program.

As you are aware, the Centers for Medicare & Medicaid Services (CMS) released the CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter on April 4, 2016. The finalized policies seek to provide stable payments to plans and make improvements to the program for plans that provide high quality care to the most vulnerable beneficiaries.

Your comments on CMS's proposed revision to the Medicare Employer Retiree Plan payment and bidding model were appreciated. CMS received many comments on this proposal, which we carefully evaluated and considered as we finalized policy for the 2017 plan year. The policy, which is supported by Medicare Payment Advisory Commission analysis, is intended to provide Medicare Employer Retiree Plans with a fair benchmark, reflective of comparable local MA trends and prices. Under this new policy, MA Organizations offering Medicare Employer Retiree Plan will need to compete for employers to contract with them for these offerings on access, quality, customer service, and wrap-around benefits. While each plan and beneficiary experience is distinct, payment under the new approach will allow Medicare Employer Retiree Plan to continue the offering of basic and supplemental benefits.

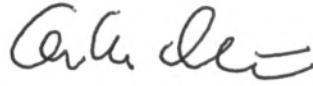
The finalized methodology for calculating Medicare Employer Retiree Plan county payments includes two important modifications based on the feedback we received:

- First, in the Advance Notice, CMS proposed to calculate the bid-to-benchmark ratios for 2017 using non-Medicare Employer Retiree Plan bids and benchmarks for 2017. However, to address timing concerns raised by commenters, CMS has calculated bid-to-benchmarks ratios for 2017 using 2016 bids and benchmarks. This revised approach will allow CMS to provide employers and insurers with information on payment rates in the Rate Announcement in April each year, rather than waiting until August.
- Second, to provide employers and plans more time to adapt to this payment change, CMS is providing a two-year transition to the new Medicare Employer Retiree Plans county payment rate methodology.

Page 2 – The Honorable Tom Price

Thank you again for taking the time to share your views. I look forward to working 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.

Sincerely,

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

Andrew M. Slavitt  
Acting Administrator

**TOM PRICE, M.D.**  
6TH DISTRICT, GEORGIA

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COMMITTEE ON THE BUDGET  
CHAIRMAN

COMMITTEE ON WAYS AND MEANS

**Congress of the United States**  
**House of Representatives**

March 11, 2016

RECEIVED

**MAR 16 2016**

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

Acting Administrator Andy Slavitt  
Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

Dear Acting Administrator Slavitt:

The Centers for Medicare & Medicaid Services (CMS) 2017 Advance Notice proposed a cut of nearly 3% to Medicare Advantage (MA) Retiree Coverage. This cut will negatively impact over a quarter of all MA beneficiaries in Georgia. That amounts to over 132,000 seniors in Georgia and 3.3 million nationwide. The state of Georgia is ranked ninth in the country for the most MA beneficiaries who will be directly impacted by this severe cut.

The value of MA Retiree Coverage is significant for seniors that depend on this effective and comprehensive care in retirement. MA Retiree Coverage offers seniors high quality coordinated care and access to disease management. We have significant concerns that the proposed cuts to MA Retiree Coverage will result in the disruption of care for Georgia seniors by increasing beneficiary premiums and out-of-pocket costs, diminishing benefit packages, and generating narrower provider networks. In fact, a recent study released on March 2<sup>nd</sup>, 2016, from Milliman, Inc. found that this proposed 3% cut will result in a devaluation of MA Retiree Coverage plans by \$19 to \$22 per senior, per month on average.

Please eliminate this cut to MA Retiree Coverage from the 2017 Final Rate Notice so that retirees in Georgia and around the country will continue to have access to affordable and high quality health care coverage.

Yours Truly,

Tom Price, M.D.



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Price:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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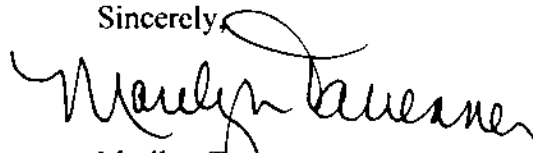
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures

CBIC / Round 2 / Bidding Suppliers / Bid Evaluation / Financial...Bidding Suppliers  
Financial Measures

The competitive bidding law and regulations specify that the Centers for Medicare & Medicaid Services (CMS) may not award a competitive bidding program contract to a supplier unless that supplier meets applicable financial standards. Applying financial standards to suppliers is needed to assess the expected quality of suppliers, estimate the total potential capacity of selected suppliers, and ensure that selected suppliers are able to continue to serve market demand for the duration of their contracts.

The Request for Bids (RFB) Instructions specifies the financial information used to evaluate suppliers' financial health. CMS uses the required tax and financial documents to calculate standard accounting ratios for each bidder.

The following financial ratios will be used for the DMEPOS Competitive Bidding Program Round 2 and national mail-order competitions:

- **Return on Sales** = Net Income (Loss)/Annual Net Sales
- **Current Ratio** = Current Assets/Current Liabilities
- **Sales to Inventory** = Annual Net Sales/Inventory
- **Collection Period** = (Accounts Receivable/Annual Net Sales) x 360
- **Working Capital** = Current Assets – Current Liabilities
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- **Quality of Earnings** = Cash Flow from Operations/(Net Income + Depreciation + Amortization)
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These ratios and the credit report and score are used to determine bidder compliance with financial standards.

*(You will need Adobe Acrobat Reader to view or print items on this page.)*

last updated on 11/30/2011

## Review of Supplier Capacity and Expansion Plans

The Medicare DMEPOS Competitive Bidding Program bid evaluation process is designed to result in a sufficient number of contract suppliers to ensure that beneficiaries throughout the competitive bidding area (CBA) have ready access to quality products and services at reasonable prices during the entire contract period. This fact sheet describes how the Centers for Medicare & Medicaid Services (CMS) conducts its review of supplier capacity and expansion plans during the bid evaluation process.

Suppliers that bid in the DMEPOS Competitive Bidding Program must provide in Form B in DBidS (the online bidding system) their estimated capacity for each item being bid. To determine estimated capacity, each supplier:

- 1 Calculates the number of units per Healthcare Common Procedure Coding System (HCPCS) code or payment class that it currently provides on a yearly basis in the CBA, and
- 2 Adds any additional units it is capable of providing throughout the entire CBA annually, beginning with the first year of the contract period.

CMS expects suppliers to be capable of sustaining this level of capacity throughout the entire contract period. Suppliers must be prepared to do so beginning on day one of the contract period. Suppliers that are new to a CBA, new to a product category, or otherwise plan to expand their capacity beyond their current levels must submit an expansion plan in Form B in DBidS. All bidders must also submit the required hardcopy financial documents specified in the Request for Bids (RFB).

The estimated capacity and financial documents are considered by CMS as part of the bid evaluation process. CMS begins the bid evaluation process by verifying bidder eligibility. All bids are checked for compliance with enrollment standards, licensure requirements, financial standards, quality standards, accreditation requirements, and other program requirements. Please note that CMS evaluates compliance with financial standards by first calculating standard accounting ratios for each bidder using the financial statements and tax extract submitted during bidding. An aggregate or total score is determined using the financial ratios and the credit score. The supplier's total financial score is then evaluated against a threshold score to determine if the supplier meets the minimum requirements to continue in the evaluation. Only suppliers that submit qualified bids are eligible for contracts.

An important step in the bid evaluation process is determining projected beneficiary demand. In the bid evaluation process, the sum of the projected capacity of eligible suppliers is compared to the projected demand. The DMEPOS Competitive Bidding Program demand calculation methodology takes into account not only the actual historic beneficiary utilization, but also considers expected changes in the number of beneficiaries enrolled and the expected growth in beneficiary services. CMS compared the projected demand calculated for the initial Round 1 to actual 2008 utilization and found that this methodology produced demand estimates well in excess of the actual utilization. This method of projecting demand helps to ensure further that a sufficient number of qualified contract suppliers is available to meet actual demand for items and services.

After calculating the projected demand, CMS sums the cumulative capacity of qualified suppliers bidding for a product category for a CBA and determines how many of these suppliers are needed to meet beneficiary demand throughout the contract period. CMS evaluates and adjusts supplier capacity as follows:

continued pg. 2

continued from pg. 1

- For Round 2, if a supplier submits an estimated capacity that is greater than 20 percent of projected beneficiary demand in the CBA, CMS will lower that supplier's capacity to 20 percent of beneficiary demand. This lowering of a supplier's projected capacity does not limit the number of items a supplier could furnish if awarded a contract. This adjustment does not apply to the national mail-order competition.
- To evaluate the capacity of a supplier that plans to expand its capacity (i.e., total estimated capacity exceeds historic claims in the CBA or product category), CMS looks at the expansion plan as well as the hardcopy financial documents to determine the ability of that supplier to furnish its estimated capacity. CMS compares each qualified bidder's total financial score (this is the same score used to determine whether a bidder meets the minimum financial requirements to participate in the program) to an expansion threshold score. If a supplier is new to an area, new to a product category, or submits estimated capacity that represents substantial growth over current levels, CMS may conduct a more detailed evaluation of that supplier's expansion plan to verify the supplier's ability to provide items and services in the CBA on day one of the contract period. If a bidder's financial health and expansion plan do not support the supplier's estimated capacity, CMS will adjust the capacity to the supplier's historic level. Adjustments to the supplier's estimated capacity have no effect on whether or not a supplier is awarded a contract.

CBIC / Round 2 / Bidding Suppliers / Bid Evaluation / Financial...

**Bidding Suppliers  
Financial Measures**

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last updated on 11/30/2011



MAY 14 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Thompson:

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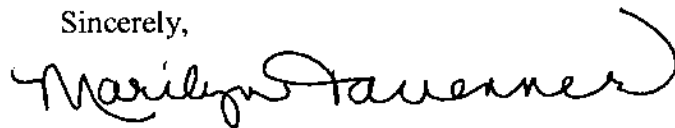
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Sincerely,

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Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Ryan:

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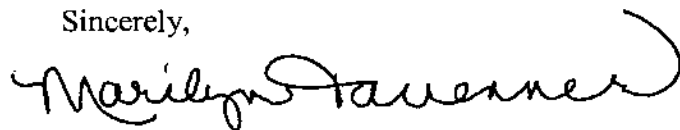
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Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Michael Fitzpatrick  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Fitzpatrick:

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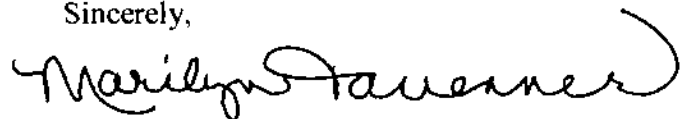
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Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Todd Rokita  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Rokita:

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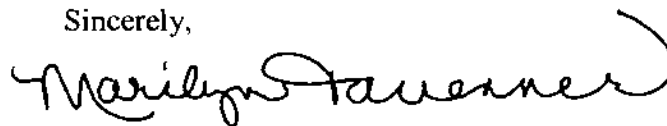
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Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Braley:

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The CMS has administered a transparent public process in both the design and operation of the program. The work performed in researching, analyzing, and designing the Medicare competitive bidding program for DMEPOS has been carried out over the past 30 years by Medicare program experts within CMS, contracts with health economists, and consultation from experts in design theory. At each and every phase of the research, design and development of Medicare's competitive bidding program, the work has been performed in consultation with the DMEPOS manufacturers, suppliers, and beneficiaries so that the expertise and advice of stakeholders is included in the process of developing the program.

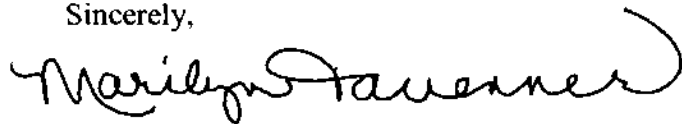
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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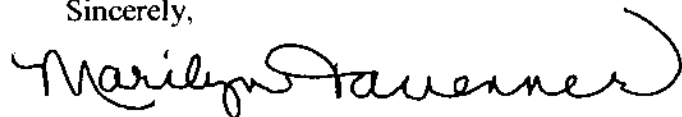
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Michael Coffman  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Coffman:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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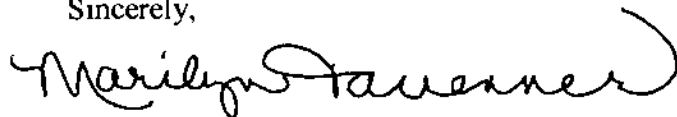
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

The Honorable Michael G. Grimm  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Grimm:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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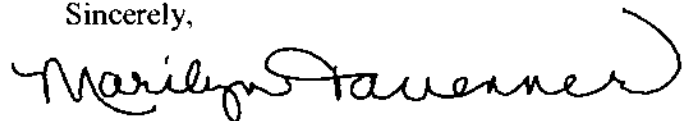
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the 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  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Roe:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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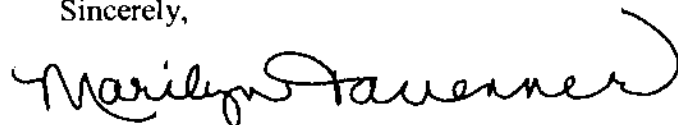
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Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Joyce:

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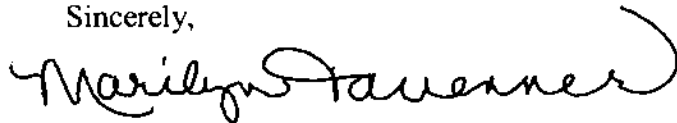
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

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

Dear Representative Blackburn:

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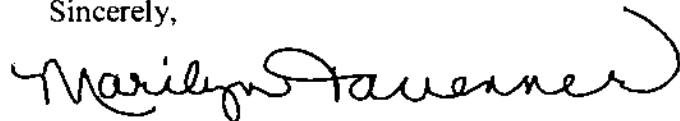
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 12 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

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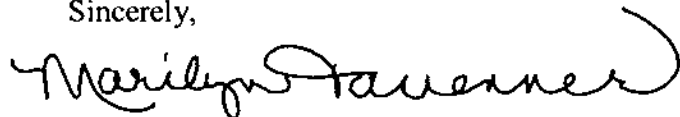
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

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

Dear Representative Rogers:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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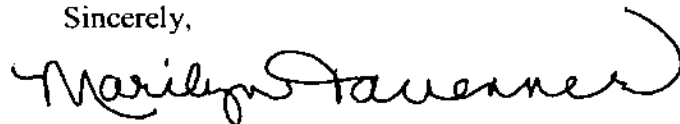
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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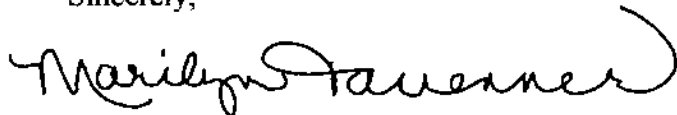
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Patrick Meehan  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Meehan:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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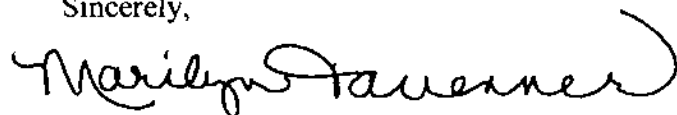
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Sincerely,



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Acting Administrator

Enclosures



*Administrator*

Washington, DC 20201

MAY 14 2013

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

Dear Representative Nunnelee:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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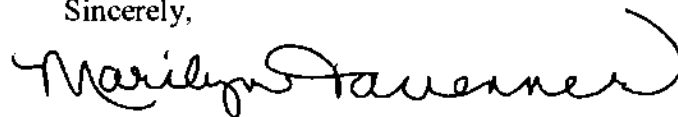
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

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

Dear Representative McKinley:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 13 2013

*Administrator*  
Washington, DC 20201

The Honorable C.W. Bill Young  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Young:

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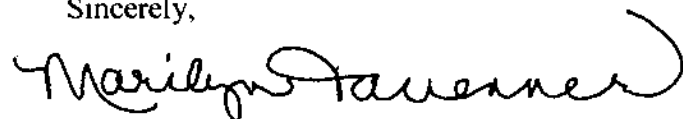
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MAY 14 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Wilson:

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While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

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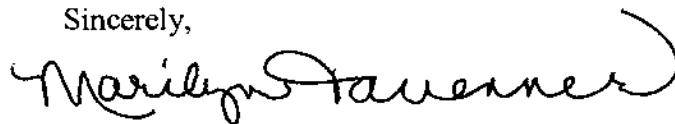
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Michael Michaud  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Michaud:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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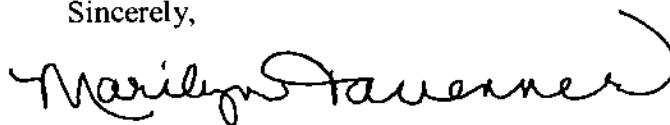
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

The Honorable Dennis Ross  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Ross:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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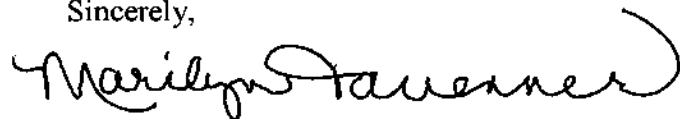
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 11 2010

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

Dear Representative Barrow:

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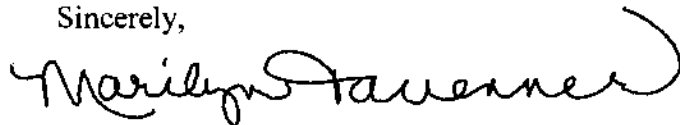
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

The Honorable Frank Wolf  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Wolf:

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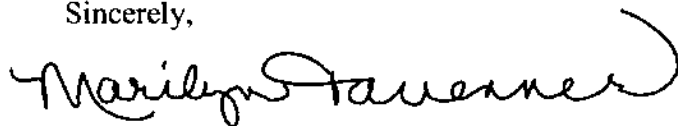
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Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Murphy:

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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Guthrie:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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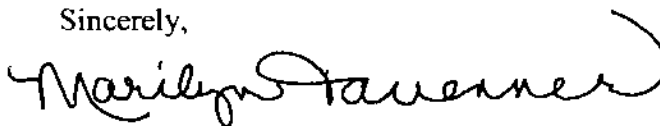
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Sincerely,



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Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Trey Gowdy  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Gowdy:

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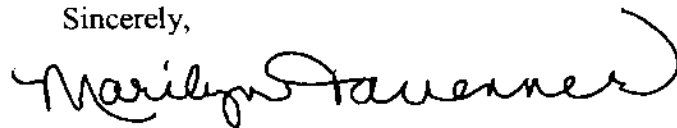
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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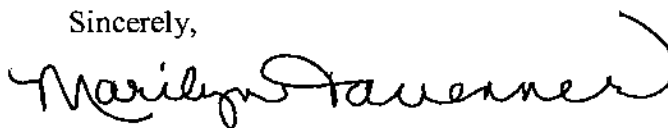
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

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

Dear Representative Westmoreland:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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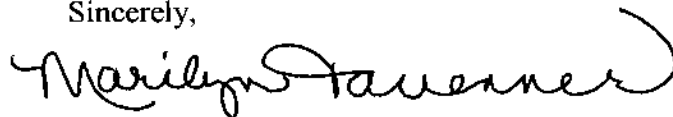
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Ed Whitfield  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Whitfield:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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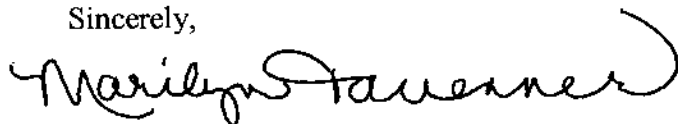
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2 2013

The Honorable Jo Bonner  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Bonner:

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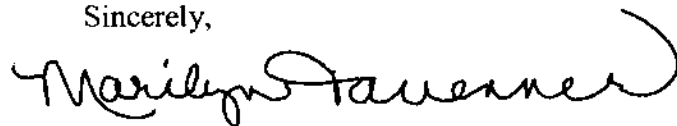
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Smith:

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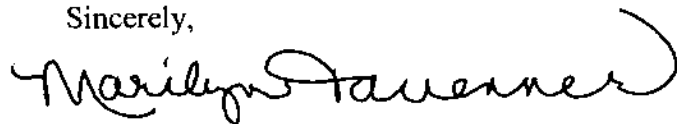
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Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Robert Wittman  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Wittman:

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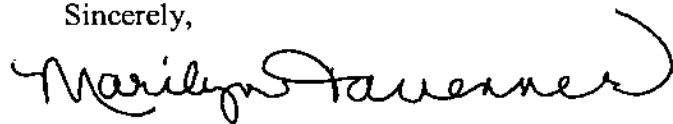
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

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

Dear Representative Johnson:

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While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

The CMS has administered a transparent public process in both the design and operation of the program. The work performed in researching, analyzing, and designing the Medicare competitive bidding program for DMEPOS has been carried out over the past 30 years by Medicare program experts within CMS, contracts with health economists, and consultation from experts in design theory. At each and every phase of the research, design and development of Medicare's competitive bidding program, the work has been performed in consultation with the DMEPOS manufacturers, suppliers, and beneficiaries so that the expertise and advice of stakeholders is included in the process of developing the program.

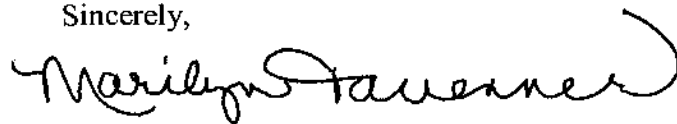
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Renacci:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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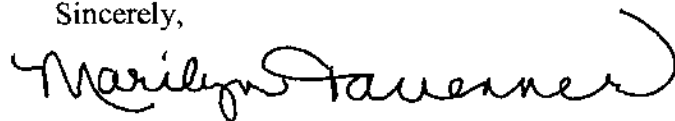
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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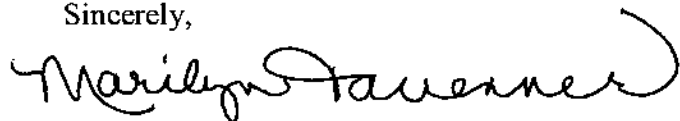
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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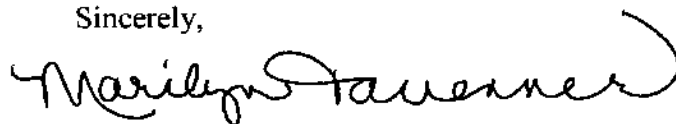
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the 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

Enclosures



MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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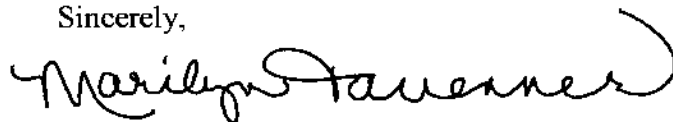
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Ruppertsberger:

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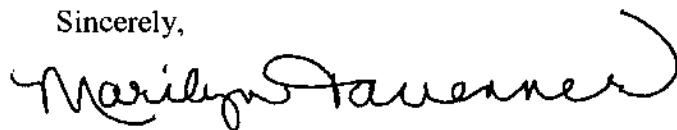
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Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

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

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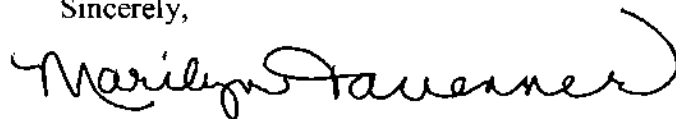
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Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Jordan:

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While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

The CMS has administered a transparent public process in both the design and operation of the program. The work performed in researching, analyzing, and designing the Medicare competitive bidding program for DMEPOS has been carried out over the past 30 years by Medicare program experts within CMS, contracts with health economists, and consultation from experts in design theory. At each and every phase of the research, design and development of Medicare's competitive bidding program, the work has been performed in consultation with the DMEPOS manufacturers, suppliers, and beneficiaries so that the expertise and advice of stakeholders is included in the process of developing the program.

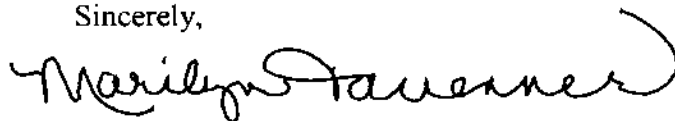
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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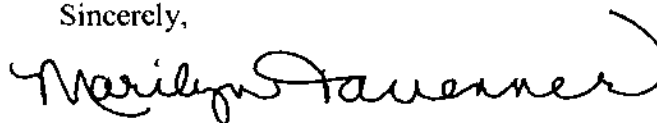
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

The Honorable Bob Gibbs  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Gibbs:

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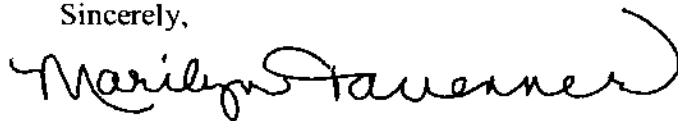
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Sincerely,

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  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Griffin:

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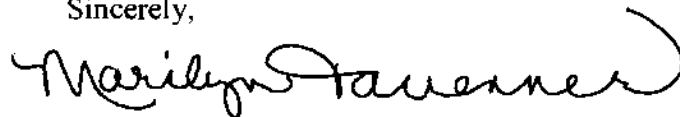
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 11 2011

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

Dear Representative Chabot:

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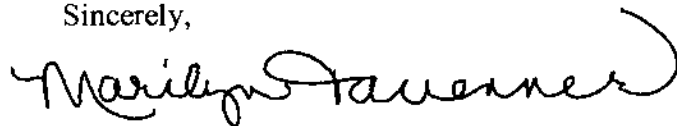
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Marino:

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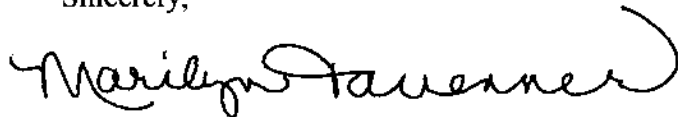
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Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

The Honorable Adam Kinzinger  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Kinzinger:

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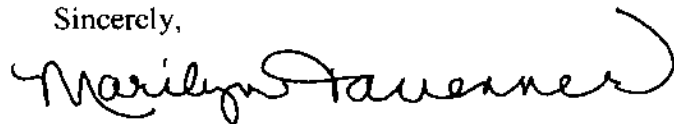
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Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

The Honorable Christopher Gibson  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Gibson:

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The CMS successfully implemented Round One of the program on January 1, 2011, in nine metropolitan areas after making a number of improvements, including new requirements from Congress, and after working closely with stakeholders. The CMS Actuary projects that the program will save \$25.8 billion for Medicare over 10 years, and save another \$17.2 billion for beneficiaries through lower coinsurance and premiums. The program has already saved in excess of \$200 million in each of its first two years of operation with no disruption in access or negative health consequences for beneficiaries based on our active surveillance and monitoring program. In addition, CMS has received only a handful of complaints from beneficiaries about the program. CMS has shared the monitoring data with the public on the CMS website and briefed staff and members of various Congressional committees. CMS has now awarded contracts to experienced national and local suppliers across the country and is scheduled to move forward on July 1 of this year to implement the program in 91 additional areas, as the law requires.

While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

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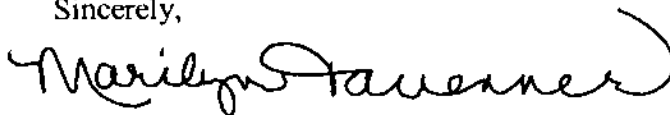
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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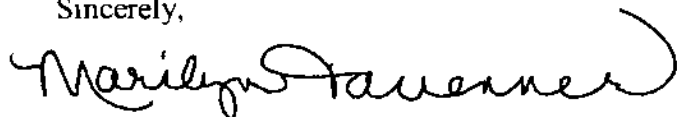
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

The Honorable Charles Boustany  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Boustany:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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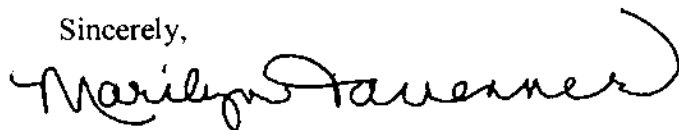
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 17 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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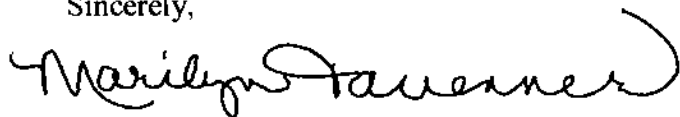
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2012

*Administrator*  
Washington, DC 20201

The Honorable Mick Mulvaney  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Mulvaney:

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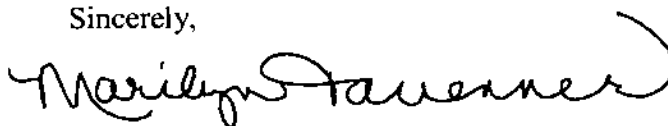
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the 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

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

The Honorable Walter Jones  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Jones:

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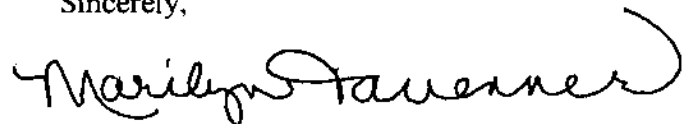
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Harper:

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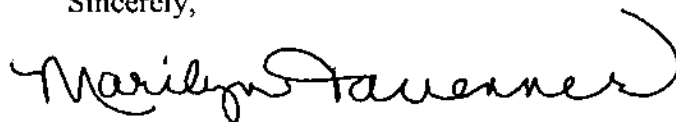
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

The Honorable Markwayne Mullin  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Mullin:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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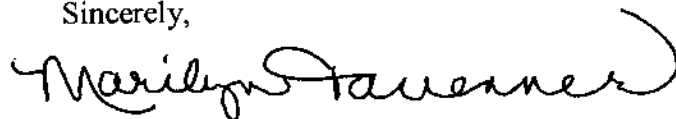
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Lankford:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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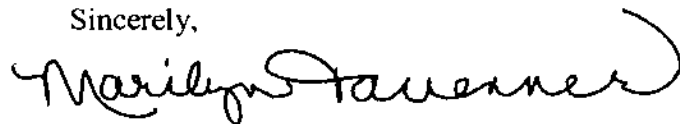
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

The Honorable Spencer Bachus  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Bachus:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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Thank you again for your letter regarding the DMEPOS competitive bidding 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 co-signers of your letter.

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 17 2013

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

Dear Representative Cohen:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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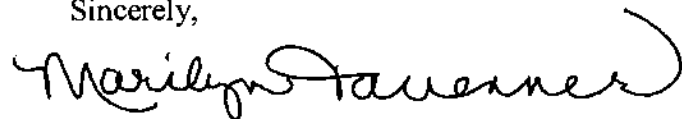
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Reed:

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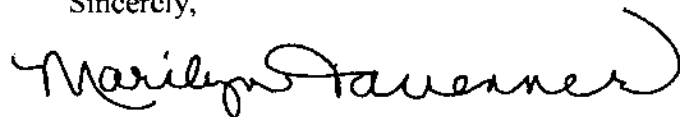
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Ellmers:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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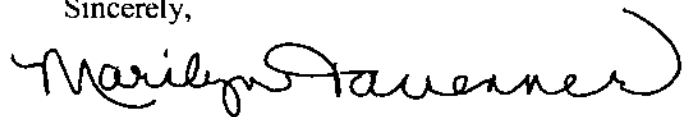
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Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Amodei:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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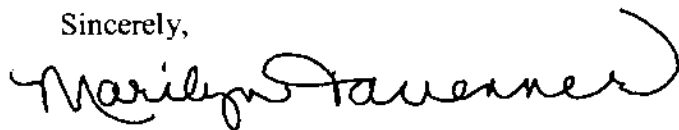
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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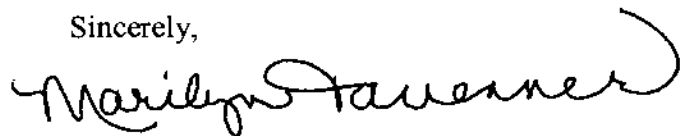
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Kelly:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

MAY 9 2013

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

Dear Representative Walberg:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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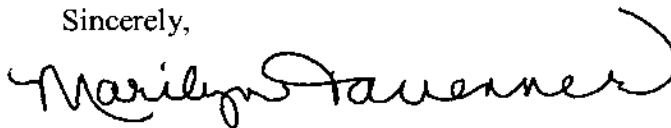
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Rothfus:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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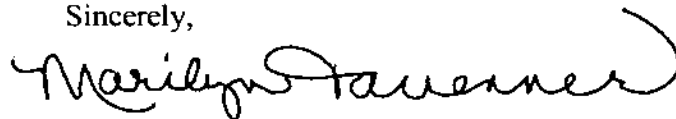
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Michael Turner  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Turner:

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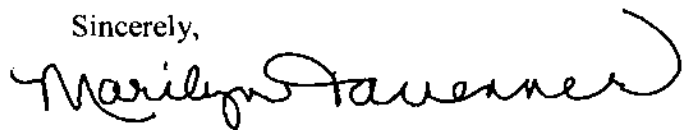
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Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Andy Barr  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Barr:

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Page 2 – The Honorable Andy Barr

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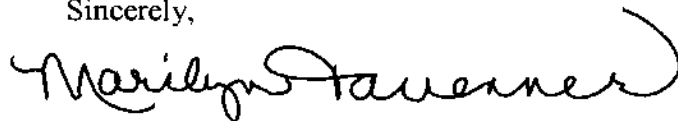
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Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*

Washington, DC 20201

MAY 7 2013

The Honorable Collin Peterson  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Peterson:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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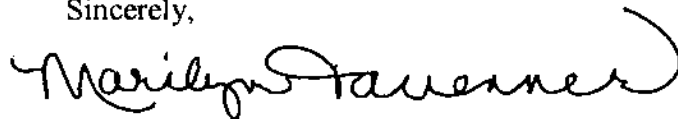
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Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Nugent:

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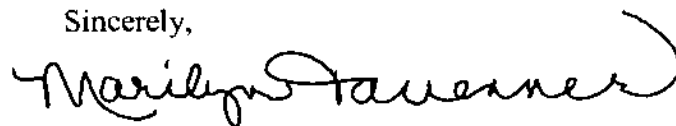
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 16 2013

*Administrator*  
Washington, DC 20201

The Honorable Robert Latta  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Latta:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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While we understand that manufacturers and suppliers are not in favor of lower Medicare prices, I can assure you that CMS's policy and process results in appropriate payment amounts. These payment amounts are based on the bids of qualified suppliers that meet strict quality and accreditation standards, financial standards, Medicare supplier standards, and state licensing requirements. Each bid is screened to ensure that it is a bona fide bid and those that fail are excluded. In both Round One and Round Two of the program, suppliers overwhelmingly accepted contract offers (92 percent) at the payment amounts set through the competition. Given recent reports by the Government Accountability Office and the Office of Inspector General documenting the excessive payment amounts in the current DMEPOS fee schedule, we would expect to see much lower payment amounts under the competitive bidding program.

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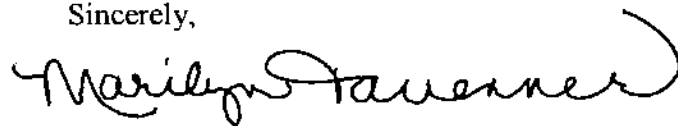
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Trent Franks  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Franks:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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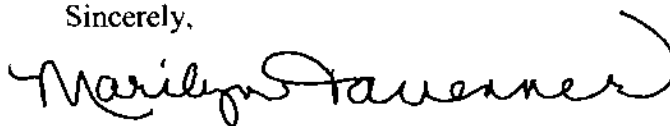
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Ralph Hall  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Hall:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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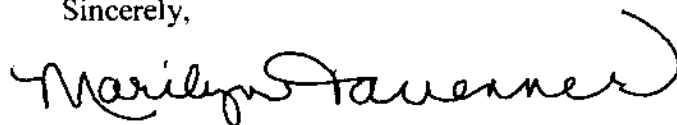
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 4 2013

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

Dear Representative Crawford:

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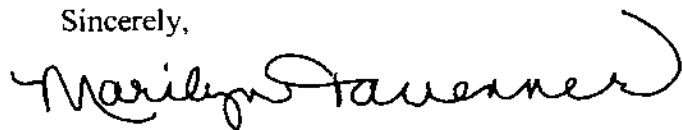
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Bob Goodlatte  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Goodlatte:

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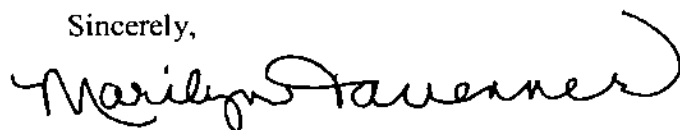
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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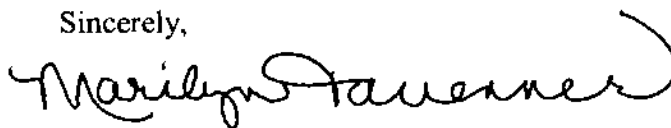
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative DesJarlais:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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Thank you again for your letter regarding the DMEPOS competitive bidding 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 co-signers of your letter.

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 3 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

The CMS successfully implemented Round One of the program on January 1, 2011, in nine metropolitan areas after making a number of improvements, including new requirements from Congress, and after working closely with stakeholders. The CMS Actuary projects that the program will save \$25.8 billion for Medicare over 10 years, and save another \$17.2 billion for beneficiaries through lower coinsurance and premiums. The program has already saved in excess of \$200 million in each of its first two years of operation with no disruption in access or negative health consequences for beneficiaries based on our active surveillance and monitoring program. In addition, CMS has received only a handful of complaints from beneficiaries about the program. CMS has shared the monitoring data with the public on the CMS website and briefed staff and members of various Congressional committees. CMS has now awarded contracts to experienced national and local suppliers across the country and is scheduled to move forward on July 1 of this year to implement the program in 91 additional areas, as the law requires.

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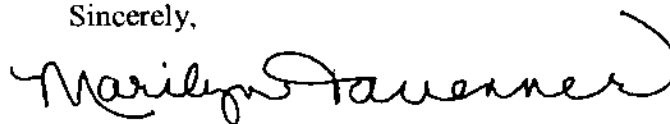
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Kline:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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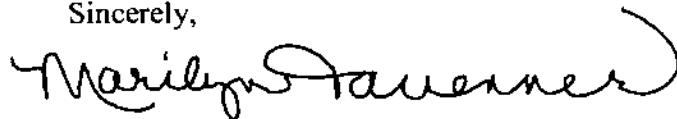
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 1 - 2013

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

Dear Representative Long:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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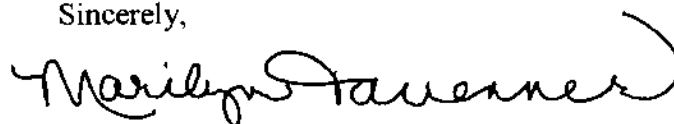
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





*Administrator*  
Washington, DC 20201

MAY 1 2013

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

Dear Representative Stivers:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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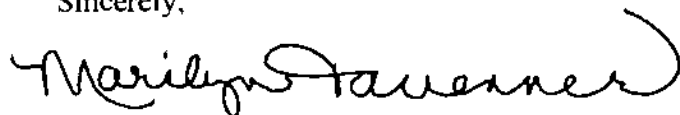
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1, 2010

*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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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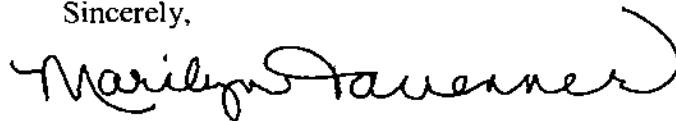
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

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

Dear Representative Barletta:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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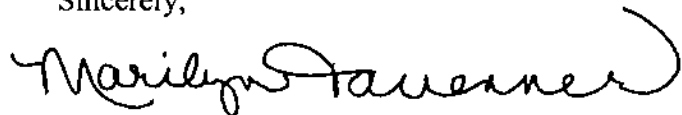
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Marilyn Tavenner  
Acting Administrator

Enclosures



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAY 14 2010

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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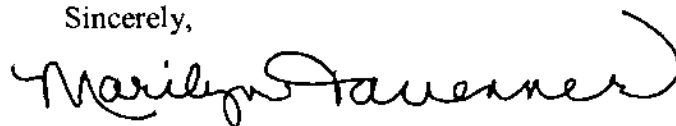
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





*Administrator*  
Washington, DC 20201

MAY 14 2013

The Honorable Rob Woodall  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Woodall:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

The CMS successfully implemented Round One of the program on January 1, 2011, in nine metropolitan areas after making a number of improvements, including new requirements from Congress, and after working closely with stakeholders. The CMS Actuary projects that the program will save \$25.8 billion for Medicare over 10 years, and save another \$17.2 billion for beneficiaries through lower coinsurance and premiums. The program has already saved in excess of \$200 million in each of its first two years of operation with no disruption in access or negative health consequences for beneficiaries based on our active surveillance and monitoring program. In addition, CMS has received only a handful of complaints from beneficiaries about the program. CMS has shared the monitoring data with the public on the CMS website and briefed staff and members of various Congressional committees. CMS has now awarded contracts to experienced national and local suppliers across the country and is scheduled to move forward on July 1 of this year to implement the program in 91 additional areas, as the law requires.

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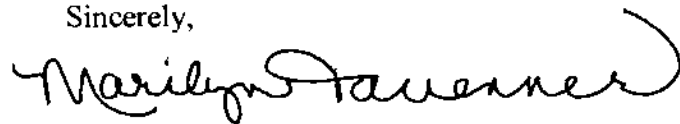
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

The Honorable Robert Pittinger  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Pittinger:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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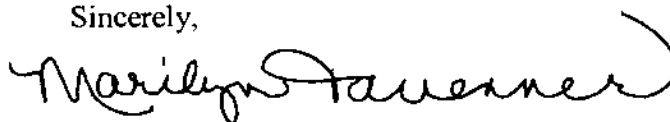
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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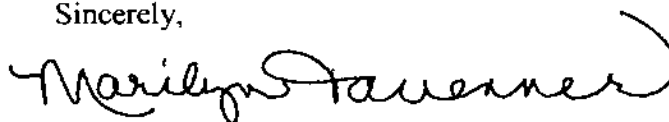
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 6 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Broun:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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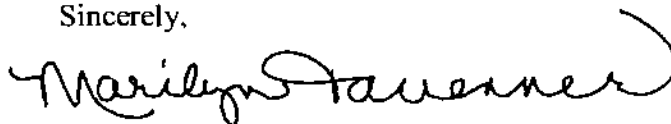
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





MAY 1 7 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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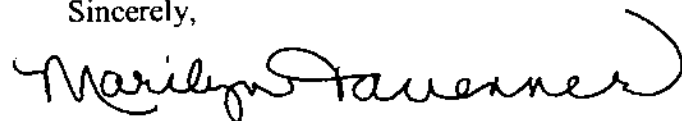
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

The Honorable Larry Buschon  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Buschon:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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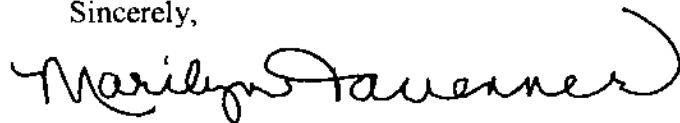
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*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 the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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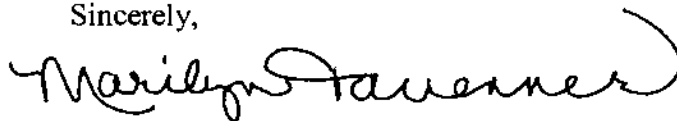
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 4 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Scalise:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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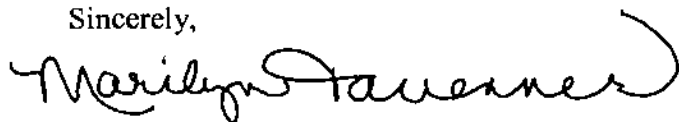
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





*Administrator*  
Washington, DC 20201

MAY 1 2013

The Honorable H. Morgan Griffith  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Griffith:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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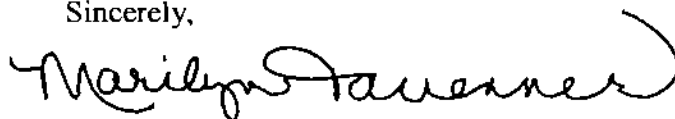
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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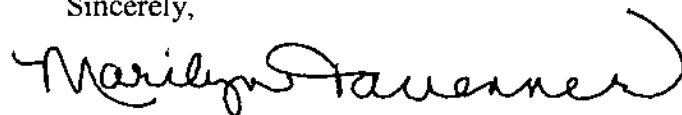
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

The Honorable Randy Forbes  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Forbes:

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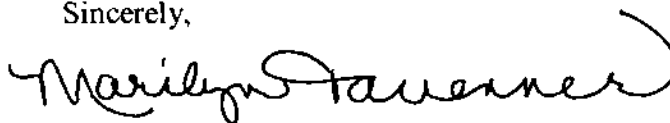
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



*Administrator*  
Washington, DC 20201

MAY 14 2013

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

Dear Representative Roskam:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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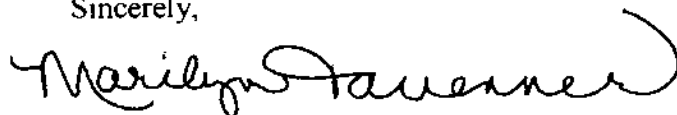
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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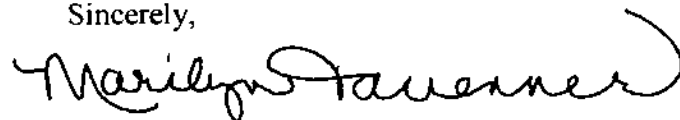
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Johnson,:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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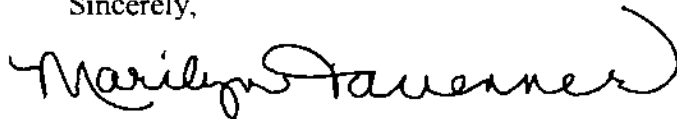
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Thank you again for your letter regarding the DMEPOS competitive bidding program. I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide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

Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 14 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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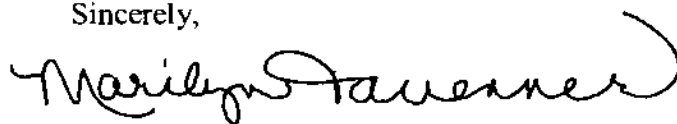
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures



MAY 1 - 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 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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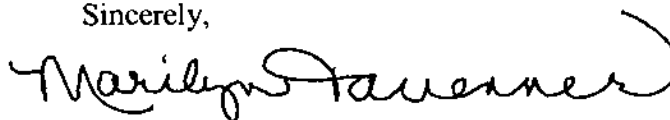
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures





*Administrator*  
Washington, DC 20201

MAY 16 2013

The Honorable Virginia Foxx  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Foxx:

Thank you for your letter regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. We are pleased that this new program has already been effective in reducing beneficiary out-of-pocket costs, providing significant savings to Medicare and tax payers, reducing over-utilization and fraud, and ensuring beneficiary access to high quality items and services. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing your concerns to our attention.

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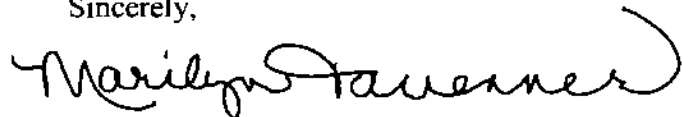
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Acting Administrator

Enclosures



MAY 1 2013

*Administrator*  
Washington, DC 20201

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

Dear Representative Crawford:

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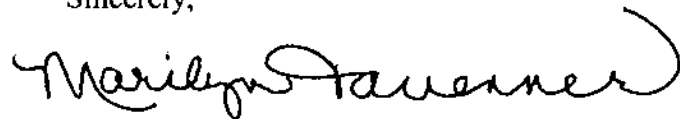
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Sincerely,



Marilyn Tavenner  
Acting Administrator

Enclosures

**Congress of the United States**  
**Washington, DC 20515**

RECEIVED  
APR 01 2013  
OSORA DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

March 15, 2013

Marilyn Tavenner, Acting Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Acting Administrator Tavenner:

We are writing to express our concern regarding the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program and the recently announced Round 2 bid prices for durable medical equipment.

As you know, Medicare published payment rates for durable medical equipment subject to Round 2 of the Competitive Bidding program. Based on Medicare's calculations, reimbursement rates will be reduced by 45% below the current Medicare fee schedule and 72% below the fee schedule for diabetic supplies as of July 1, 2013. Furthermore, the national mail order program for diabetic supplies will impact every diabetic Medicare beneficiary in the United States.

Congress, in the *Medicare Modernization Act of 2003*, designed the Competitive Bidding program with the intention of reducing Medicare and beneficiary expenditures through competition while ensuring that beneficiaries continue to have access to quality items. However, the current CMS-designed program is neither competitive nor does it protect beneficiary access to high quality medical supplies. In fact, many patients will likely have to find a new supplier, often in another state.

There are numerous flaws in the Competitive Bidding program that prevent it from ensuring quality and access for Medicare beneficiaries. As just one example, the program does not ensure that bidders are qualified to provide the products in the bid markets.

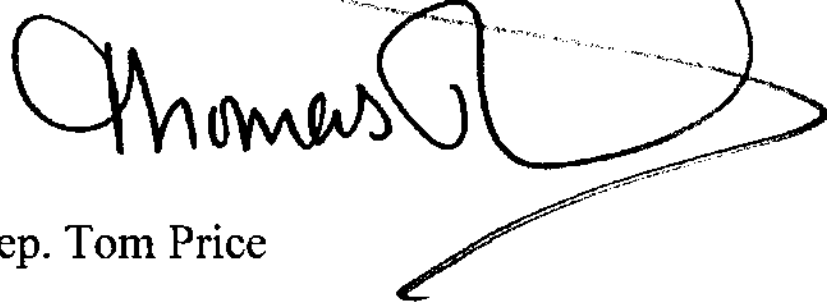
Furthermore, the lack of transparency surrounding the Competitive Bidding program from the Centers for Medicare and Medicaid Services is a source of major concern for patients, providers, and Congress alike. Therefore, we respectfully request the following information:

- The financial standards used to determine if a provider is qualified to bid.
- How patient demand in given metropolitan statistical areas is determined.
- Details about how provider capacity to meet patient demand is determined.

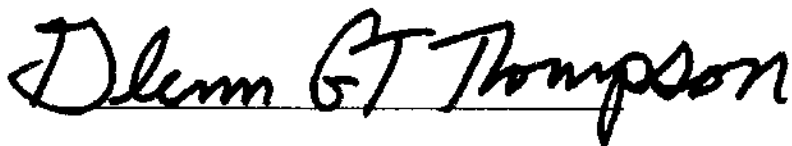
- Whether CMS would consider a delay in implementation of Round 2.

We continue to hear the concerns surrounding the DMEPOS Competitive Bidding program from patients and providers in our districts. American businesses all across this country as well as the aging and vulnerable Medicare population they serve are potentially at-risk due to the way in which CMS is implementing this program. We look forward to your timely response to these concerns.

Yours truly,




Rep. Tom Price



Rep. Glenn Thompson



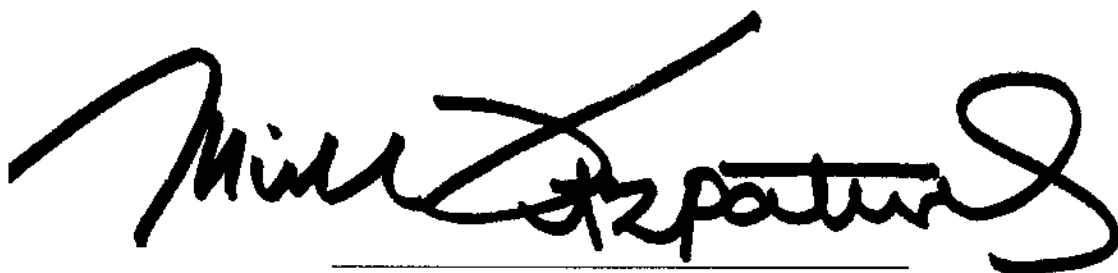
Rep. Todd Rokita



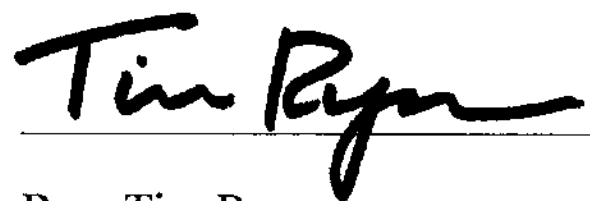
Rep. Paul Ryan



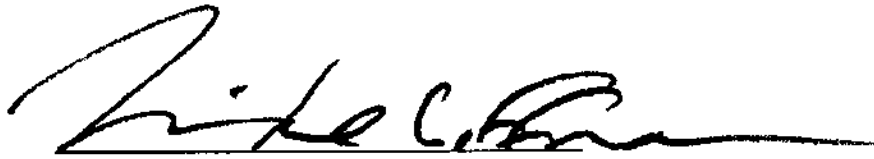
Rep. Bruce Braley



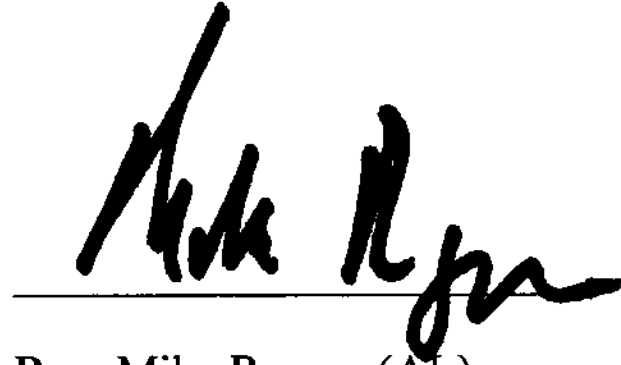
Rep. Michael Fitzpatrick



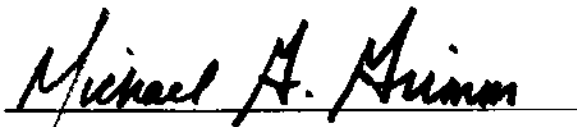
Rep. Tim Ryan



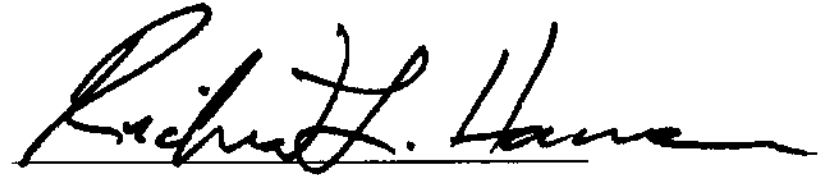
Rep. Michael Coffman



Rep. Mike Rogers (AL)



Rep. Michael Grimm



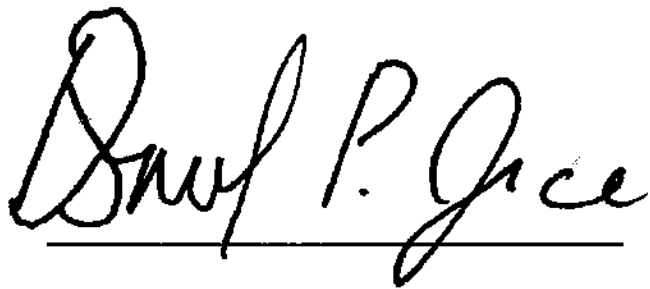
Rep. Richard Hanna



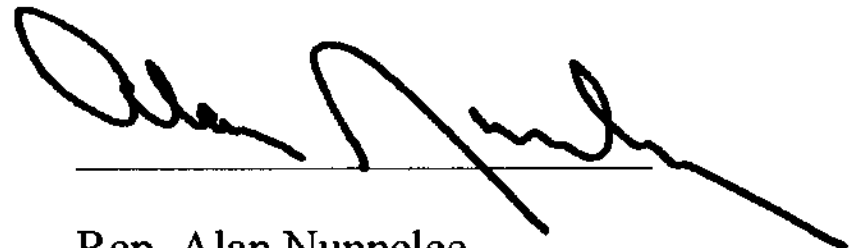
Rep. David P. Roe



Rep. Patrick Meehan



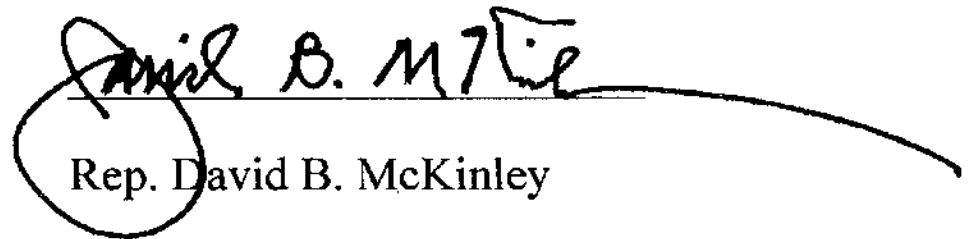
Rep. David Joyce



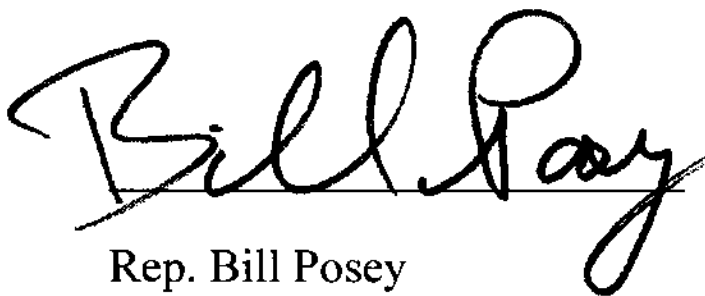
Rep. Alan Nunnelee



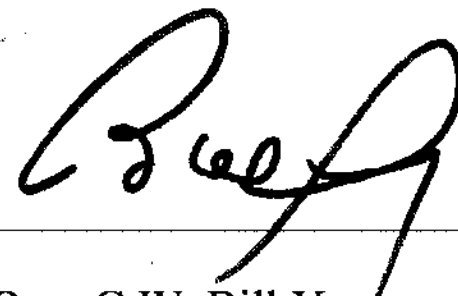
Rep. Marsha Blackburn



Rep. David B. McKinley



Rep. Bill Posey




Rep. C.W. Bill Young



Rep. Joe Wilson



Rep. Brett Guthrie



Rep. Michael Michaud



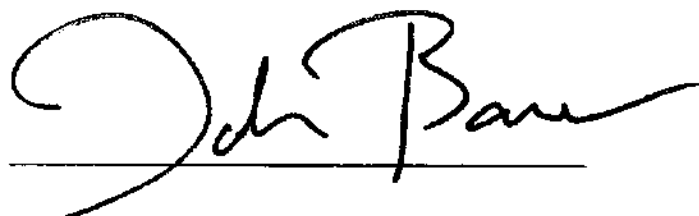
Rep. Trey Gowdy



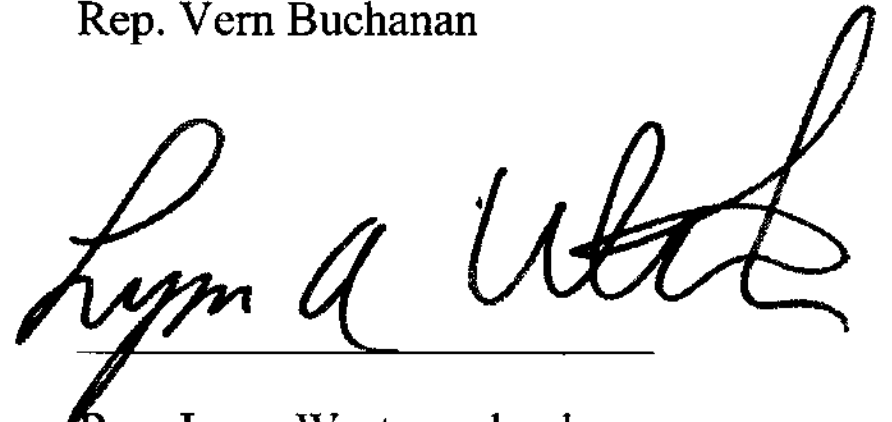
Rep. Dennis Ross



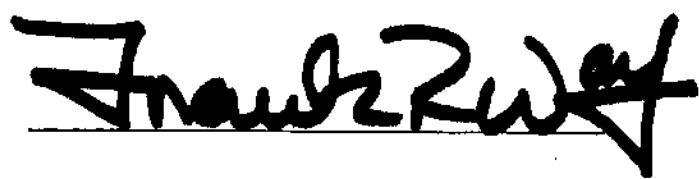
Rep. Vern Buchanan



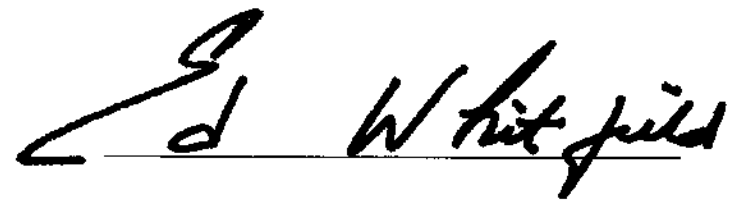
Rep. John Barrow



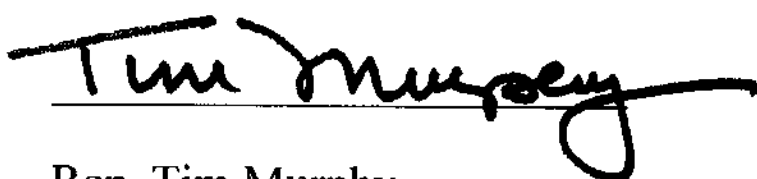
Rep. Lynn Westmoreland



Rep. Frank Wolf



Rep. Ed Whitfield



Rep. Tim Murphy

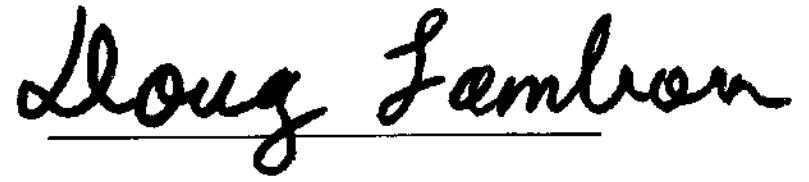


Rep. Jo Bonner






Rep. Christopher Smith



Rep. Doug Lamborn



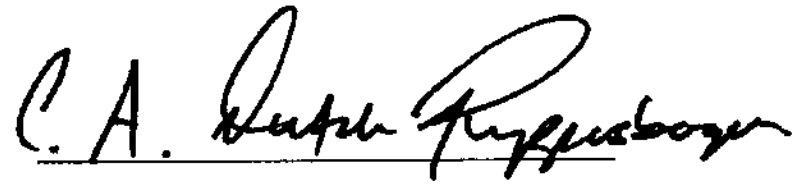
Rep. Robert Wittman



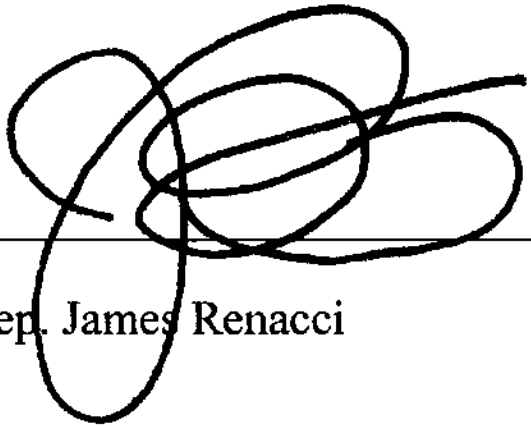
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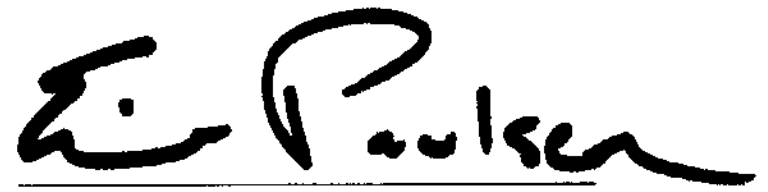
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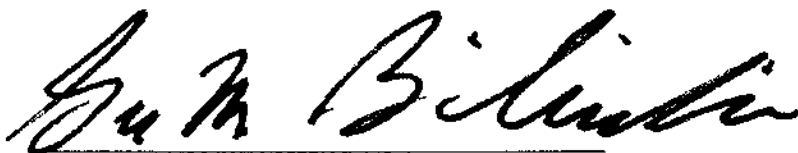
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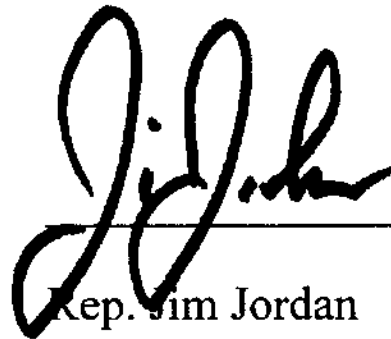
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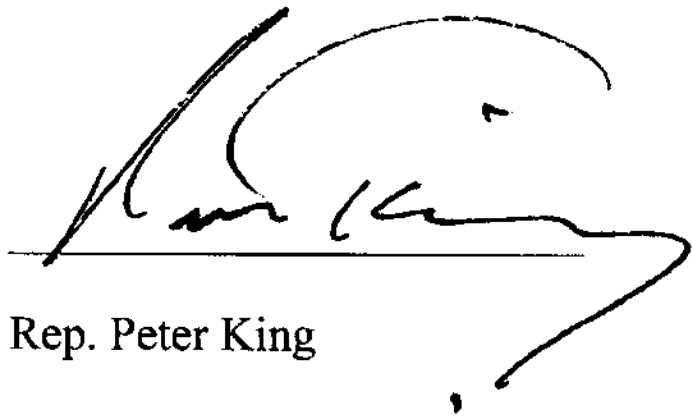
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Rep. Gus Bilirakis



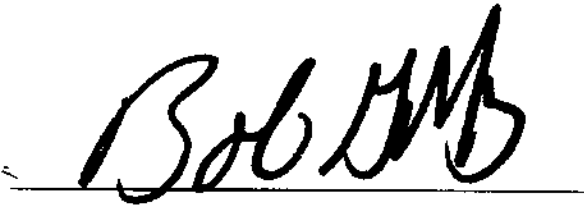
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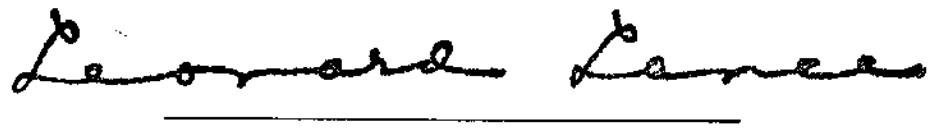
Rep. Peter King



Rep. Christopher Gibson



Rep. Bob Gibbs



Rep. Leonard Lance



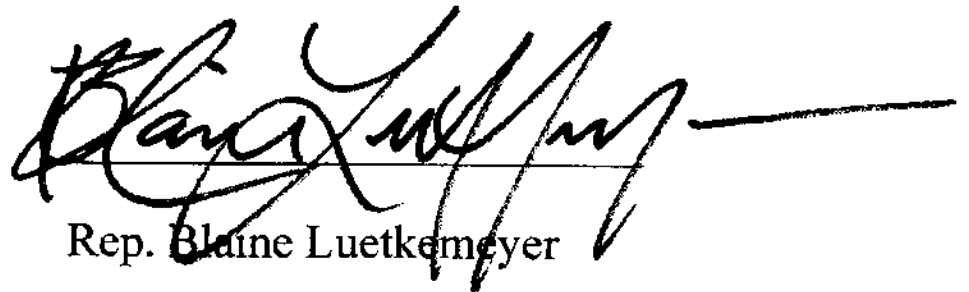
Rep. Tim Griffin



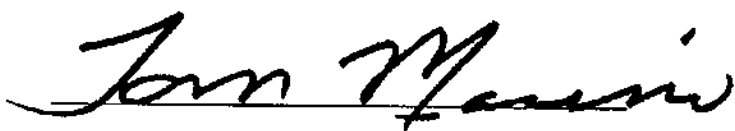
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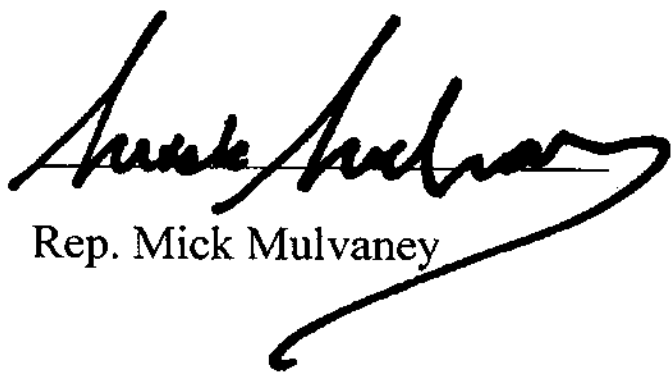
Rep. Steve Chabot



Rep. Blaine Luetkemeyer



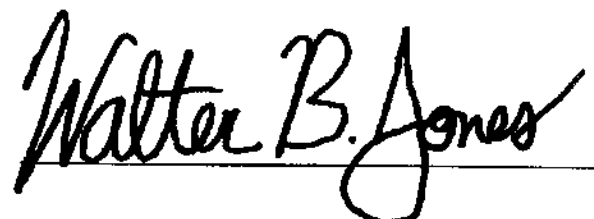
Rep. Tom Marino



Rep. Mick Mulvaney



Rep. Adam Kinzinger



Rep. Walter Jones

Gregg Harper

Rep. Gregg Harper

Renee Ellmers

Rep. Renee Ellmers

Markwayne Mullin

Rep. Markwayne Mullin

Mark A. Amodei

Rep. Mark Amodei

James Lankford

Rep. James Lankford

Robert Hurt

Rep. Robert Hurt

Spencer Bachus

Rep. Spencer Bachus

Mike Kelly

Rep. Mike Kelly

Steve Cohen

Rep. Steve Cohen

Tim Walberg

Rep. Tim Walberg

Tom Reed

Rep. Tom Reed

Keith Rothfus

Rep. Keith Rothfus

Michael R. Turner

Rep. Michael Turner

Ralph M. Hall

Rep. Ralph Hall

Andy Barr

Rep. Andy Barr

Rick Crawford

Rep. Rick Crawford

Collin Peterson

Rep. Collin Peterson

Bob Goodlatte

Rep. Bob Goodlatte

Richard Nugent

Rep. Richard Nugent

Todd Young

Rep. Todd Young

Robert Latta

Rep. Robert Latta

Scott DesJarlais

Rep. Scott DesJarlais

Trent Franks

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Lynn Jenkins

Rep. Lynn Jenkins

John Kline  
Rep. John Kline

Rob Woodall  
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Billy Long  
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Robert Pittenger  
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Steve Stivers  
Rep. Steve Stivers

Diane Black  
Rep. Diane Black

Shelley Moore Capito  
Rep. Shelley Moore Capito

Paul Broun  
Rep. Paul Broun

Lou Barletta  
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Aaron Schock  
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Austin Scott  
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Larry Busch  
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Rodney Davis

Rep. Rodney Davis

Niki Tsongas

Rep. Niki Tsongas

Steve Scalise

Rep. Steve Scalise

Hank Johnson

Rep. Henry C. "Hank" Johnson, Jr.

H. Morgan Griffith

Rep. H. Morgan Griffith

Lamar Smith

Rep. Lamar Smith

Kristi Noem

Rep. Kristi Noem

Ileana Ros-Lehtinen

Rep. Ileana Ros-Lehtinen

Randy Forbes

Rep. Randy Forbes

Virginia Foxx

Rep. Virginia Foxx

Peter Roskam

Rep. Peter Roskam

Eric Crawford

Rep. Eric A. "Rick" Crawford



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAY 31 2016

Administrator  
Washington, DC 20201

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

Dear Representative Price:

Thank you for sharing your thoughts regarding our proposed Part B Drug Payment Model. The Centers for Medicare & Medicaid Services (CMS) appreciates you bringing these views to our attention.

As you note, CMS has issued a proposed rule describing a new Part B Drug Payment Model that would test a two-phase model whether alternative drug payment designs may improve how Medicare Part B pays for prescription drugs and supports physicians and other clinicians in delivering higher quality care. This proposal is part of the Administration's broader strategy to encourage better care, smarter spending, and healthier people by paying for what works, unlocking health data, and finding new ways to coordinate and integrate care to improve quality. More specifically, this proposed rule is designed to test different physician and patient incentives to do two things: drive the prescribing of the most effective drugs and test new payment approaches that reward positive patient outcomes.

The comment period for the proposed rule closed on May 9, 2016. We have included your comments as part of the public record. We will carefully consider the public comments on this proposal that we received during the public comment period in developing a 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. 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".

Andrew M. Slavitt  
Acting Administrator

**Congress of the United States**  
**Washington, DC 20515**

May 2<sup>nd</sup>, 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 write to express our deep concerns regarding the Centers for Medicare & Medicaid Services (CMS) "Part B Drug Payment Model" proposed rule, published in the *Federal Register* on March 11, 2016. CMS's proposed Medicare drug experiment would unnecessarily disrupt care for the sickest seniors who depend on Medicare, including those with cancer, macular degeneration, rheumatoid arthritis, neurological disorders, rare diseases and primary immunodeficiency diseases. Given these concerns outlined here, we ask that CMS withdraw this proposed rule that could endanger access to care for America's most vulnerable seniors.

CMS's proposed Medicare experiment would impose cuts in Phase I that will severely harm patient access to needed drugs. Under CMS's Medicare drug experiment, numerous physicians would face acquisition costs that exceed the Medicare payment amount for certain drugs. This policy will make it harder for patients to receive the drugs they need and especially hurt seniors who depend on doctors in smaller practices or those who live in rural areas.

The scope of the proposed experiment on drugs for seniors is also deeply troubling. CMS proposes forcing nearly 75% of the country to participate in the Medicare drug experiment. The impact on patients will be sweeping and affect seniors across the country.

CMS's proposed Medicare drug experiment would also lead physicians to refer patients to a hospital outpatient department (HOPD). Driving more care to an often less convenient, more costly setting makes it more challenging for beneficiaries to access needed care and increases overall Medicare costs. This will lead to further consolidation and less choice for seniors.

The policies in the proposed Part B model were developed with no input from outside experts and those with real-world experience. CMS should have consulted with affected stakeholders considering the proposal's broad scope and risk for beneficiaries.




We are concerned that the proposed model will hinder physician efforts to participate in delivery and payment reforms, including the Oncology Care Model (OCM) and the various alternative payment models (APMs) incentivized by the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). OCM practices have voluntarily engaged to make changes aimed at bringing more value through a model that CMS established in close consultation with stakeholders. Layering cuts on top of sweeping systematic changes will hurt efforts at payment reform in Medicare.

We are also concerned that the proposal fails to state how CMS will assess the impact on the quality of care beneficiaries receive. The proposal states an expectation that the model will reduce Part B drug spending while maintaining the quality of care beneficiaries receive, yet it does not provide the specifics of how access and quality will be assessed throughout the duration of the model or in the evaluation phase. Understanding the quality metrics used to determine whether there are acute problems or what constitutes the ultimate success of the model is critically important. Yet CMS failed to address this in their proposed rule.

This experiment affects all our constituents, Democrat or Republican, and we believe that Congress, whose responsibility is to the electorate, is best tasked with making these decisions, not an unaccountable entity. Every American should have their voices heard rather than be silenced by Washington politics.

Given the numerous concerns regarding this rule and the impact it will have on Medicare seniors' access to lifesaving drugs, we again urge CMS to withdraw this proposed regulation.

Sincerely,



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



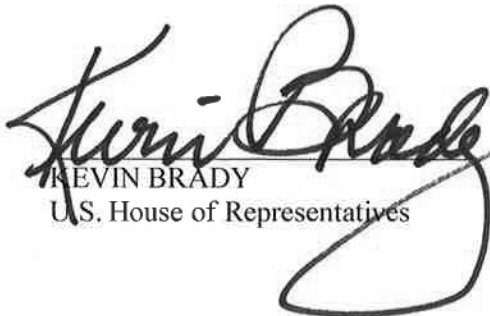
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JOHN SHIMKUS  
U.S. House of Representatives



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CHARLES BOUSTANY JR., M.D.  
U.S. House of Representatives




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KEVIN BRADY  
U.S. House of Representatives



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FRED UPTON  
U.S. House of Representatives



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STEVE SCALISE  
U.S. House of Representatives

Hal Rogers Lamar Smith Ed Royce

Bob Goodlatte Paul Ryan Steve Chabot

K. Michael Conaway John Kline Bill Shuster

Eric Chaffetz Rep. Sessions John Garamella

Clayton MacArthur Larry Bucshon

Judith Menendez Conrad A. Mitchell Robert F. Cold

Carly Fiorina Bob Latta Michael T. McCarver

W. By <sup>TX-20</sup> MP Hinshelwood Chris Smith

John R. Cant Walter B. Jones Doug Landon

[Signature] Virginia Fox Lal Q. Lucas

Paul Bush John Culberson [Signature]

Collin C. Peterson [Signature] [Signature]

Mike Simpson Mike Thompson Frank A. Bobb

L. N. Child Andrew Scott [Signature]

Jeff Pomeroy Bill Johnson Todd Ritter

~~Rick~~ CPA Judy Alice

Alvin Jeff Zerkow Paul

Midland Mike Kelly Jim Jackson

Lynn Jenkins Kristen Simons MacGaid

Lilly Long Dan Auerhouse P. H. by

Paul Cook C.A. Dutch Pappaschungen Bill Posey

John Rodney Davis Drphy

Rich Belmont Jan M. W. W. W. David Brown

Geoff Pathway Frankie Plank Genevieve M. Lummis

Jim Walberg [Signature] Bill Davis

Tom Graves Mike Coffey Rich E. Jotta

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Billy Ford Lou Bonletta Red Boy

John Moore Erik Pauls Alan Jussel

Bruce Wooten John M Al R

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Barbara Comstock D. G. Chuck Fleish

Robert B. Adams David Young Missi P

Mike Fagan Bob Dick Richard Hudson

Mike Bishop Earl L. Buddy Carter Pat O'Brien

Gene Wagner Myrl Tompkins Joe Joe

Merlin Kelly Mac Smith Ever Jenkins

Tom Furrer Sholy Paul A. Jones, MS

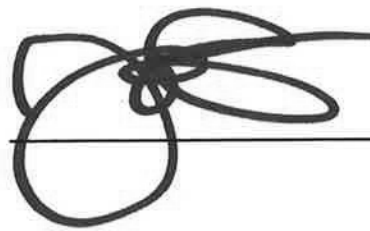
Rick W. Allen Dan Burchett Caeser Hardy


Frank B. Anderson Joe Ford Walter Thompson

~~Gregg Harper~~ Gregg Harper PRD

Thomas Massie Vian Baber Day La Melf

Ch Stewart John Ratelle Fred Monte

 Dan Brat Dave P. Roe

Tom Marino Jim B. M. Tie 

LA-05 Pat Riggall Jackie Walorski

Joseph R. Pitts Die Rouye Ryan Costello



Quinn Black Pat Tilley Keith J Rothfus

Anthony Wally Rene Elling

Bill Hizey John Robert Williams

J. French Hill Alex M. Mandy Trey Gandy

Fred R. Winters Sam Paul J. H.

Carl Carl Andy Barr M. Bond

Dug Cell Susan Brooks Bob Riddle

Devin Young | Devin New

John (04-15) | John Hill | Paul P. Ryan

Key Strong | Chris Collins | Mark R. Warner

Blake Fustell | Stacy Womack | Martha McSally

Ben Fran | Markwayne Mullin | Daniel Webster

Brian Casper | Wendell Smith | Richard

Jaime Herrera Beutler | John Curtis | John M. McEnaney

Joe Branton W. M. Bickler Pete Olson

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9 Whitfield Drey Walden Lynn A. Westmacott

Ken Calvert Scott Smith Vicky Hartzler

Shirley Pittman Jerry Jordan Carrie Smith

Joe Guncamp Sam Johnson Tom Schunt

Steve King Mike Michael R. Amodeo

Joe Wilson Butler

Tim Murphy

Don Young

Nike Strupatnik

Leonard Lance

Chris Smith

Doug Stanton

Paul D Lucas

J. Pittsford Synthia D. Lummis Tom Graves

Brett Guthrie

Tim Walberg

Wick Coffey

Roe E. Jatta

Van Baker

Harsh Blackburn

Ken Hest

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Pedro P. Zamora

Mark Walker W.C. 06 W. Linn Paul Pledge

Pete King D. M. Lat Paul Pledge

Ken Buck Paul K. Weber ATWY

Harry Johnson R. M. P. Elmer M. Stanford

Will Hard Ted S. York M. Brooks

Raul R. Sabrad Jeff Miller

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The Honorable Tom Price, M.D.  
The Honorable John Shimkus  
The Honorable Charles Boustany Jr., M.D.  
The Honorable Kevin Brady  
The Honorable Fred Upton  
The Honorable Steve Scalise  
The Honorable Mac Thornberry  
The Honorable Candice Miller  
The Honorable Steve Chabot  
The Honorable Bill Shuster  
The Honorable Charles W. Dent  
The Honorable Michael T. McCaul  
The Honorable Luke Messer  
The Honorable Patrick McHenry  
The Honorable Cathy McMorris-Rodgers  
The Honorable Lamar Smith  
The Honorable John Kline  
The Honorable Jeb Hensarling  
The Honorable Robert W. Bishop  
The Honorable Harold Rogers  
The Honorable Pete Sessions  
The Honorable Michael Conaway  
The Honorable Bob Goodlatte  
The Honorable Edward R. Royce  
The Honorable Jason Chaffetz  
The Honorable Jeff Miller  
The Honorable Robert Dold  
The Honorable Larry Bucshon, M.D.  
The Honorable Michael C. Burgess, M.D.  
The Honorable Randy Hultgren  
The Honorable Michael G. Fitzpatrick  
The Honorable Brett Guthrie  
The Honorable Tom Cole  
The Honorable Rodney Davis  
The Honorable Tom Reed  
The Honorable Tim Walberg  
The Honorable David W. Jolly  
The Honorable Frank Lucas  
The Honorable Doug Lamborn  
The Honorable Bob Latta

The Honorable Robert J. Wittman  
The Honorable Stephen Fincher  
The Honorable Kristi Noem  
The Honorable Daniel M. Donovan, Jr.  
The Honorable Richard Nugent  
The Honorable F. James Sensenbrenner, Jr.  
The Honorable Darren LaHood  
The Honorable Christopher H. Smith  
The Honorable Tom Graves  
The Honorable Jeff Denham  
The Honorable Mike Coffman  
The Honorable Cynthia M. Lummis  
The Honorable Virginia Foxx  
The Honorable Walter B. Jones  
The Honorable Frank A. LoBiondo  
The Honorable Stevan Pearce  
The Honorable Ted Poe  
The Honorable Blaine Luetkemeyer  
The Honorable John L. Mica  
The Honorable Tom McClintock  
The Honorable Collin C. Peterson  
The Honorable Mick Mulvaney  
The Honorable Duncan Hunter  
The Honorable John R. Carter  
The Honorable Michael Simpson  
The Honorable David A. Trott  
The Honorable Austin Scott  
The Honorable Trent Franks  
The Honorable John Culberson  
The Honorable Patrick Meehan  
The Honorable Rod Blum  
The Honorable Ryan A. Costello  
The Honorable Barbara Comstock  
The Honorable Gregg Harper  
The Honorable George Holding  
The Honorable Mimi Walters  
The Honorable Mike Rogers  
The Honorable Paul A. Gosar, D.D.S .  
The Honorable Scott DesJarlais, M.D.  
The Honorable Brad Ashford

The Honorable Tom Marino  
The Honorable Doug LaMalfa  
The Honorable Scott Tipton  
The Honorable Ann Wagner  
The Honorable Erik Paulsen  
The Honorable Joseph R. Pitts  
The Honorable Bradley Byrne  
The Honorable Bruce Westerman  
The Honorable David Rouzer  
The Honorable Rick Allen  
The Honorable David P. Roe, M.D.  
The Honorable Mike Pompeo  
The Honorable Bob Gibbs  
The Honorable Robert Pittenger  
The Honorable David Young  
The Honorable Earl L. "Buddy" Carter  
The Honorable Robert B. Aderholt  
The Honorable Steve Russell  
The Honorable James B. Renacci  
The Honorable Richard Hudson  
The Honorable Dan Benishek, M.D.  
The Honorable John R. Moolenaar  
The Honorable Mike Bishop  
The Honorable Chris Stewart  
The Honorable Dennis A. Ross  
The Honorable Lou Barletta  
The Honorable Ron DeSantis  
The Honorable David B. McKinley  
The Honorable Martha Roby  
The Honorable Jackie Walorski  
The Honorable Glenn "GT" Thompson  
The Honorable Jim Bridenstine  
The Honorable Mia Love  
The Honorable Crescent Hardy  
The Honorable Ralph L. Abraham Jr., M.D.  
The Honorable Mark E. Amodei  
The Honorable Charles J. Fleischmann  
The Honorable Brian Babin, D.D.S.  
The Honorable Frank C. Guinta  
The Honorable Evan Jenkins



The Honorable Mario Diaz-Balart  
The Honorable Glenn Grothman  
The Honorable Tom Rice  
The Honorable Kevin Yoder  
The Honorable Scott E. Rigell  
The Honorable Joe Heck, D.O.  
The Honorable Tom Emmer  
The Honorable Dave Brat  
The Honorable John Ratcliffe  
The Honorable Garret Graves  
The Honorable Barry Loudermilk  
The Honorable Thomas Massie  
The Honorable Jason Smith  
The Honorable Andy Barr  
The Honorable Bill Flores  
The Honorable Steve Womack  
The Honorable Kevin Cramer  
The Honorable Diane Black  
The Honorable Devin Nunes  
The Honorable French Hill  
The Honorable Morgan H. Griffith  
The Honorable David G. Valadao  
The Honorable Adam Kinzinger  
The Honorable Patrick J. Tiberi  
The Honorable Mike Bost  
The Honorable Markwayne Mullin  
The Honorable Carlos Curbelo  
The Honorable Chris Collins  
The Honorable Susan Brooks  
The Honorable Steve Knight  
The Honorable Keith Rothfus  
The Honorable Renee Ellmers  
The Honorable Bill Huizenga  
The Honorable David B. Reichert  
The Honorable David P. Joyce  
The Honorable Steve Stivers  
The Honorable Todd Young  
The Honorable Doug Collins  
The Honorable Daniel Webster  
The Honorable Scott Perry

The Honorable Martha McSally  
The Honorable Brad R. Wenstrup, D.P.M.  
The Honorable Sean P. Duffy  
The Honorable Sam Graves  
The Honorable John Katko  
The Honorable Alex Mooney  
The Honorable Blake Farenthold  
The Honorable Randy Neugebauer  
The Honorable Roger Williams  
The Honorable Mark Meadows  
The Honorable Jaime Herrera Beutler  
The Honorable Kay Granger  
The Honorable Reid J. Ribble  
The Honorable Trey Gowdy  
The Honorable Vern Buchanan  
The Honorable Greg Walden  
The Honorable Leonard Lance  
The Honorable Marsha Blackburn  
The Honorable Tim Murphy, M.D.  
The Honorable Thomas J. Rooney  
The Honorable Ed Whitfield  
The Honorable Gus M. Bilirakis  
The Honorable Joe Barton  
The Honorable Adrian Smith  
The Honorable Pete Olson  
The Honorable Peter J. Roskam  
The Honorable Kenny Marchant  
The Honorable Lynn Westmoreland  
The Honorable Scott Garrett  
The Honorable Sam Johnson  
The Honorable Rodney P. Frelinghuysen  
The Honorable Vicky Hartzler  
The Honorable Matt Salmon  
The Honorable Ken Calvert  
The Honorable Don Young  
The Honorable John Fleming, M.D.  
The Honorable Louie Gohmert  
The Honorable John J. Duncan Jr.  
The Honorable Ileana Ros-Lehtinen  
The Honorable Darrell E. Issa

The Honorable Michael R. Turner  
The Honorable Joe Wilson  
The Honorable Randy J. Forbes  
The Honorable Steve King  
The Honorable Ander Crenshaw  
The Honorable Mike Kelly  
The Honorable Billy Long  
The Honorable Lynn Jenkins  
The Honorable Bill Johnson  
The Honorable Jeff Fortenberry  
The Honorable Andy Harris, M.D.  
The Honorable Lee Zeldin  
The Honorable Todd Rotika  
The Honorable Eric A. Crawford  
The Honorable Jody Hice  
The Honorable Dan Newhouse  
The Honorable Ken Buck  
The Honorable Peter T. King  
The Honorable Steven Palazzo  
The Honorable Krysten Sinema  
The Honorable Ted S. Yoho  
The Honorable Mark Walker  
The Honorable Jeff Duncan  
The Honorable Jim Jordan  
The Honorable Bill Posey  
The Honorable Elise Stefanik  
The Honorable Randy Weber  
The Honorable Will Hurd  
The Honorable Bruce Poliquin  
The Honorable Robert Hurt  
The Honorable David Schweikert  
The Honorable Ryan Zinke  
The Honorable Trent Kelly  
The Honorable Chris Gibson  
The Honorable Paul Cook  
The Honorable Richard L. Hanna  
The Honorable Curt Clawson  
The Honorable C.A. Dutch Ruppertsberger  
The Honorable Gary Palmer  
The Honorable Mo Brooks

The Honorable Tom MacArthur

The Honorable Raúl Labrador



JUN 10 2010

*Administrator*  
Washington, DC 20201

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

Dear Dr. Price:

Thank you for your letter regarding the transitional pass-through payment policy under Medicare's hospital outpatient prospective payment system (OPPS). The Centers for Medicare & Medicaid Services (CMS) greatly appreciates you bringing your concerns to our attention.

You express concern that CMS has not approved a device for pass-through payment in nearly 3 years. We share your goal that truly innovative devices that bring improved clinical outcomes to Medicare beneficiaries should be encouraged. Therefore, CMS carefully evaluates each pass-through application for a new device category to ensure that it meets all applicable pass-through criteria. These evaluations are completed by a panel of CMS physicians who are trained in various specialties.

Since 2003, CMS has approved 10 devices under this process for pass-through payment. Each application has been reviewed according to the same standards by our clinical panel, and our evaluation process has not changed since we last approved a device for pass-through payment in 2007. Concerning the pass-through application for the bioactive polymer composite for vertebral augmentation, please be aware that although we did not approve the initial application, we are currently reconsidering the application at the request of the applicant. As with all evaluations, we will give this device careful and deliberate consideration. We previously met with the applicant, and recently met with them again to discuss their reconsideration request.

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

Sincerely,

Marilyn Tavenner  
Acting Administrator and Chief Operating Officer



JUN 10 2010

*Administrator*  
Washington, DC 20201

The Honorable John Barrasso, M.D.  
United States Senate  
Washington, DC 20515

Dear Dr. Barrasso:

Thank you for your letter regarding the transitional pass-through payment policy under Medicare's hospital outpatient prospective payment system (OPPS). The Centers for Medicare & Medicaid Services (CMS) greatly appreciates you bringing your concerns to our attention.

You express concern that CMS has not approved a device for pass-through payment in nearly 3 years. We share your goal that truly innovative devices that bring improved clinical outcomes to Medicare beneficiaries should be encouraged. Therefore, CMS carefully evaluates each pass-through application for a new device category to ensure that it meets all applicable pass-through criteria. These evaluations are completed by a panel of CMS physicians who are trained in various specialties.

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

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner  
Acting Administrator and Chief Operating Officer

**Congress of the United States**

Washington, DC 20515

RECEIVED

April 30, 2010

MAY 4 2010

DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

Ms. Marilyn Tavenner  
Principal Deputy Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Ave SW, Room 314G  
Hubert Humphrey Building  
Washington, D.C. 20201

Dear Principal Deputy Administrator Tavenner:

As orthopedic surgeons with a combined total of over 50 years practice experience, we have a strong interest in government policies impacting patient access to new, innovative medical devices and treatment therapies. That is why we write to express our concerns about the Centers for Medicare and Medicaid Services (CMS) transitional device "pass-through" policy.

In August 2000, the CMS implemented a new prospective payment system for hospital outpatient services (HOPPS). Congress subsequently passed the Balanced Budget Refinement Act (BBRA) mandating changes to the new HOPPS system. The BBRA approved temporary, additional Medicare payments or "transitional pass-through payments" for certain innovative medical devices, drugs, and biologics. Congress intended these items be available to Medicare patients – even if prices for the new and innovative items exceeded Medicare's regularly set HOPPS payment amounts.

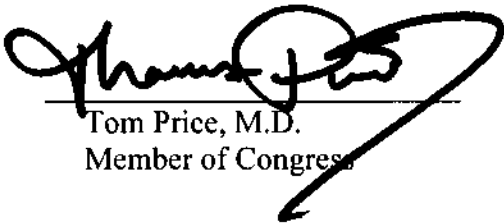
In November 2001, CMS issued final regulatory guidance outlining the transitional pass-through payment eligibility criteria. This regulation required, among other things, that new devices and technologies "offer substantial clinical improvement in the treatment of Medicare beneficiaries". We support this requirement as a way to incentivize manufacturers to develop cutting-edge therapies and devices. Medicare patients deserve access to new, life-saving, and even life-altering medical technologies. To accomplish both goals, we believe the federal government simply must provide adequate and predictable reimbursement to manufacturers and participating providers – acknowledging the substantial financial investment required to research, develop, and bring to market these novel products.

It has come to our attention; however, that recent CMS application of the pass-through payment policy may not specifically follow Congressional intent. CMS has not approved any transitional pass-through payment applications in nearly three years. For example, the Food and Drug Administration (FDA) recently approved a novel, bioactive polymer composite for vertebral augmentation. The FDA cleared the product based on a clinical trial comprised of 256 patients showing: 1) statistically significant improvements in pain and function; 2) reductions in subsequent adjacent level fractures; 3) reductions in subsequent vertebral augmentation procedures; and 4) reductions in re-hospitalizations for spinal fracture.

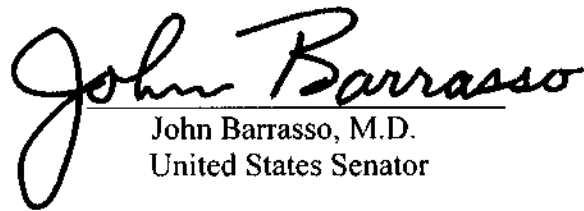
It is our understanding that the denial of the vertebral augmentation pass-through payment application has the potential to negatively affect patients. This is not an isolated example as CMS has failed to approve pass-through payments in nearly three years. We respectfully request CMS work to improve this area so that together we can make the process more transparent and predictable. The pass-through payment application process should not be so onerous that it stifles medical innovation – ultimately restricting Medicare patient access to new devices, therapies, and drugs.

We believe uninterrupted patient care, improved patient outcomes, and avoiding increased patient spending are strong justifications for CMS to reconsider the new vertebral augmentation composite application and reassess its pass-through payment application process.

Yours Truly,



Tom Price, M.D.  
Member of Congress



John Barrasso, M.D.  
United States Senator

cc: Mr. Jonathan Blum  
Deputy Administrator for Medicare

Ms. Liz Richter  
Deputy Director of the Center for Medicare Management

Ms. Amy Bassano  
Director of the Hospital and Ambulatory Policy Group

Mr. Christine Smith-Ritter  
Acting Director of the Division of Outpatient Care



**Congress of the United States**  
**Washington, DC 20515**

December 11, 2008

RECEIVED

JAN 21 2009

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

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. If you have any questions, please contact Erin Doty in Congressman Shuler's office at [erin.doty@mail.house.gov](mailto:erin.doty@mail.house.gov) (225-6401) or Emily Henehan in Congressman Tom Price's office at [emily.henehan@mail.house.gov](mailto:emily.henehan@mail.house.gov) (225-4501).

Sincerely,

Mae White



*Administrator*  
Washington, DC 20201

AUG 08 2012

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

Dear Representative Price:

Thank you for your letter regarding Medicare coding and payment for Vertos Medical's minimally invasive treatment for lumbar spinal stenosis. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

Vertos Medical's *mild*® procedure currently may be covered and paid at local Medicare contractor discretion using a category III Current Procedural Terminology (CPT) code. Category III CPT codes are used temporarily to describe emerging technologies. The CPT Editorial Panel may create a permanent category I CPT code when it retires a category III code. CMS often receives requests to create Healthcare Common Procedure Codes (HCPCS) for items or services. However, our longstanding practice has been to create codes only when there is a statutory or regulatory program need for which a CPT code is unavailable, or the CPT code is incompatible with Medicare statute or regulations. At this time, there is no statutory or regulatory provision that would necessitate creation of a HCPCS code for Vertos Medical's *mild*® procedure. We suggest that Vertos Medical continue to work with the CPT Editorial Panel to create a category I CPT code.

Your letter indicates that relative values for surgical approaches to treat lumbar spinal stenosis have not been updated for 15 years. CMS has been engaged in a vigorous effort over the past several years to identify potentially misvalued codes and, when codes are found to be misvalued, to revise the payment accordingly. We thank you for bringing this family of codes to our attention and we will consider making these services part of the misvalued code initiative.

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-signer of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner  
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

AUG 08 2012

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

Dear Representative Cassidy:

Thank you for your letter regarding Medicare coding and payment for Vertos Medical's minimally invasive treatment for lumbar spinal stenosis. 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  
Acting Administrator

BILL CASSIDY, M.D.  
6TH DISTRICT, LOUISIANA  
COMMITTEE ON  
ENERGY AND COMMERCE  
SUBCOMMITTEE ON HEALTH  
SUBCOMMITTEE ON  
ENVIRONMENT AND ECONOMY  
SUBCOMMITTEE ON  
COMMERCE, MANUFACTURING AND TRADE



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

WASHINGTON OFFICE:  
1535 LONGWORTH HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515  
PHONE: (202) 225-3301  
FAX: (202) 225-7313

DISTRICT OFFICE:  
5555 HILTON AVENUE, SUITE 100  
BATON ROUGE, LA 70808  
PHONE: (225) 929-7711  
FAX: (225) 929-7688

<http://cassidy.house.gov>  
<http://facebook.com/RepBillCassidy>

June 20, 2012

Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare and Medicaid Services  
200 Independence Ave., SW  
Room 314G  
Washington, DC 20201

Dear Administrator Tavenner:

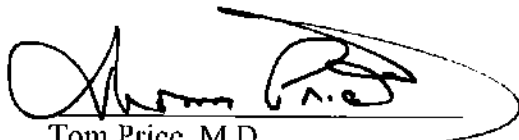
We are writing to you concerning a Medicare coverage and access issue that has recently come to my attention regarding the availability of a minimally invasive, cost effective treatment option for Medicare beneficiaries who suffer from spinal conditions such as lumbar spinal stenosis (LSS).

We understand that Vertos Medical, a device company, has developed a safe and efficacious technique to treat Medicare beneficiaries and other patients with LSS by using the *minimally invasive lumbar decompression* procedure or *mild®*. We have spoken with providers unaffiliated with Vertos who treat LSS and they have confirmed that this is a significant therapy that we need to advance. However, due to a number of technical coding and payment policy hurdles, many beneficiaries do not have access to the technology and may be forced to undergo a more invasive and expensive treatment option, which requires hospitalization.

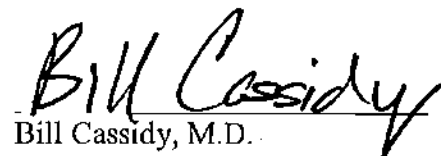
In order to resolve the coding and local coverage issues with this technology, Vertos Medical, at the suggestion of CMS, pursued the American Medical Association's (AMA) Current Procedural Terminology (CPT) coding process. However, the professional group representatives responsible for the spinal care specialty within the AMA's CPT Editorial Panel have made no change to the CPT coding for this technology. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislatively mandates the use of the AMA's CPT codes for coding and billing, it also requires the use of the CMS' Healthcare Common Procedure Coding System (HCPCS). CMS has the authority to develop procedure codes within the HCPCS manual to serve the needs of the Medicare program and its beneficiaries when the AMA CPT coding process is inadequate.

Ensuring that Medicare participating providers and beneficiaries have access to choose amongst all available technologies allows for physicians and patients to determine the best appropriate treatment plan for them. We are concerned about the lack of access that beneficiaries would have to all available and appropriate treatment options for LSS, including those that are most cost effective for the Medicare program at a time when the solvency of the program is of such significant concern to all Americans. We request that CMS exercise its authority to utilize the HCPCS coding process in this case, or explain the reason for inaction in this area. Thank you for your attention to this matter.

Sincerely,



Tom Price, M.D.  
Member of Congress



Bill Cassidy, M.D.  
Member of Congress

Cc: Jonathan Blum



JUL 30 2014

*Administrator*  
Washington, DC 20201

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

Dear Dr. Price:

Thank you for your letter regarding the New Technology request for CardioMEMS™ HF (Heart Failure) System in the Hospital Inpatient Prospective Payment System and Long Term Care Hospital Prospective Payment System (IPPS/LTCH) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The IPPS/LTCH proposed rule went on display on April 30, with a 60-day comment period that ended on June 30. We appreciate your interest in seeing CardioMEMS™ HF System approved for a new technology add-on payment 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 determination in the final regulation, along with a summary of the comments and our responses. We typically publish the IPPS/LTCH final rule on or about August 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. 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 fluid and cursive, with the first name "Marilyn" being more prominent.

Marilyn Tavenner

**TOM PRICE, M.D.**  
6TH DISTRICT, GEORGIA

WASHINGTON, DC OFFICE:  
100 CANNON HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515  
(202) 225-4501  
FAX: (202) 225-4656

DISTRICT OFFICE:  
85-C MILL STREET, SUITE 300  
ROSWELL, GA 30075  
(770) 998-0049  
FAX: (770) 565-7570

[www.house.gov/tomprice](http://www.house.gov/tomprice)



**Congress of the United States**  
**House of Representatives**

COMMITTEE ON WAYS AND MEANS

COMMITTEE ON THE BUDGET  
VICE CHAIRMAN

COMMITTEE ON EDUCATION  
AND THE WORKFORCE

DEPUTY WHIP

July 15, 2014

RECEIVED

JUL 23 2014

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

The Honorable 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:

The proposed Inpatient Prospective Payment System (IPPS) rule for 2015 includes an invitation for comments on several New Technology DRG Add-On Payment applications. I am writing to bring to your attention a new device to monitor pulmonary artery pressure produced by CardioMEMS, an Atlanta-based company.

Heart failure is one of the most prevalent and costly chronic medical conditions, affecting more than one in seven Medicare beneficiaries. Remote monitoring technologies offer the potential to improve management of chronic conditions, enabling providers to offer better-quality care at a lower cost. The CardioMEMS HF system includes a miniaturized sensor that measures pulmonary artery pressure and wirelessly transmits this data to a secure website that is accessed by the patient's clinical care team. It also generates automatic alerts to the patient's physician if pressure readings fall outside a preset range. In this way, the CardioMEMS technology may allow physicians to initiate more timely interventions and prevent hospitalizations. In fact, data from an FDA clinical trial demonstrated an approximately one-third reduction in heart failure-related hospitalizations for patients with pulmonary artery pressure monitoring.

We respectfully request that you give full consideration to the CardioMEMS new technology application to ensure appropriate access for Medicare beneficiaries.

Sincerely,

Thomas Price, MD  
Member of Congress





DEPARTMENT OF HEALTH & HUMAN SERVICES

Administrator  
Centers for Medicare & Medicaid Services

Chief Administrative Law Judge  
Office of Medicare Hearing and Appeals

OCT 15 2014

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

Dear Dr. Price:

Thank you for your letter concerning the Centers for Medicare & Medicaid Services' (CMS') Medicare Recovery Audit program and the backlog of claims at the Department of Health and Human Services' (HHS') Office of Medicare Hearings and Appeals (OMHA). We share your concern about delayed hearings for providers (as well as suppliers) who have appealed Qualified Independent Contractor (QIC) reconsiderations of Medicare claims denials to OMHA. We assure you that HHS has taken significant actions to address this challenge.

Congress established the Medicare Fee-for-Service (FFS) Recovery Audit program in 2009 to help ensure Medicare payments are being appropriately made. It is one of a number of tools CMS has to reduce improper payments and prevent fraud. In total, CMS manually reviews less than 0.3 percent of claims each year through programs such as the Recovery Audit program. Since full implementation in FY 2010 through the third quarter of FY 2014, the Recovery Audit program has recovered \$8.8 billion in improper payments. CMS uses the results of audits performed by the Recovery Auditors to identify potential vulnerabilities and take appropriate corrective actions to prevent future improper payments. As CMS has enhanced its efforts to prevent or recoup improper payments, however, provider and supplier appeals of payment denials have also increased.

We are always looking for ways to reduce the burden on providers, and we have received feedback on the Recovery Audit program from many stakeholders, including physicians and medical specialty societies. In response to this feedback, CMS has made a series of improvements to the program. Providers will have more time to engage with Recovery Auditors with a new 30-day discussion period that we anticipate will help resolve technical disputes. Recovery Auditors will receive their contingency fee only after the second level of appeal is exhausted. A more detailed description of these program improvements is enclosed. CMS is confident that these changes with the next Recovery Audit Program contract awards will result in a more effective and efficient program, including improved accuracy, decreased provider burden, and more transparency. Our goal is to balance our responsibilities to ensure all beneficiaries maintain access to care while providers and suppliers are paid promptly, and to ensure all Medicare claims are paid accurately, with a fair, impartial, and timely administrative review process for appellants.

It is important to note that CMS's Recovery Auditors apply the same Medicare policies and regulations as other Medicare contractors. These regulations and other policies, such as local coverage determinations, are open to public comments. We would encourage stakeholders to

participate in these feedback processes. Further, all review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For some reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both are aware of and approve of what the Recovery Auditors are reviewing and that they have the correct interpretation of the policies used in their audit methodologies. For other types of reviews, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

The CMS has implemented measures designed to reduce the backlog of provider appeals and to reduce the number of appeals that reach the third level of appeal at OMHA (the Administrative Law Judge (ALJ) level). On August 29, 2014, CMS announced a new effort to address the **current** backlog of appeals, available for those appeals where the claim was denied due to incorrect inpatient status with dates of admission before October 1, 2013. Incorrect inpatient status denials occur when the physician admits a Medicare beneficiary as inpatient while the medical record supports the provision of care in a hospital outpatient or other non-hospital based setting. For these cases, CMS is offering an administrative agreement to hospitals willing to withdraw pending appeals in exchange for partial payment (68 percent) of eligible inpatient claims. The deadline for hospitals to submit settlement requests to CMS is October 31, 2014. More information is available at: <http://go.cms.gov/InpatientHospitalReview>. CMS also plans to expand a prior authorization demonstration for Power Mobility Devices (PMD), which helps ensure proper payment while reducing PMD claim denials and appeals.

The OMHA has also taken steps to operate more efficiently in the face of increased provider appeals. Despite relatively stable funding levels over the years, OMHA's ALJs were previously able to handle a steadily growing workload by increasing productivity and using resources more efficiently. Indeed, OMHA judges have doubled their productivity rate over the last three years. To reduce the current backlog, OMHA recently announced that it is offering two new options for appellants to resolve their pending claim appeals. The first facilitates resolution of large numbers of claims based upon resolution of a statistically valid sample. The second uses alternative dispute resolution techniques during a facilitated settlement conference. More information can be found at: <http://www.hhs.gov/omha/>. OMHA has also increased its adjudicatory capacity by adding 10 new ALJs at the beginning of August. Six of these new ALJs reported to a new OMHA field office in Kansas City, Missouri. This is the first new field office since OMHA opened its doors in July 2005. It marks a significant step in the future expansion of the agency in order to meet increasing demands.

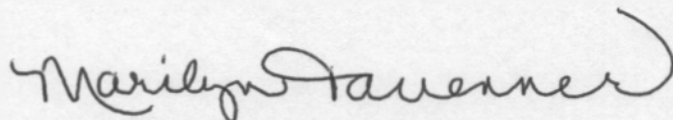
We appreciate your comments about the implementation of the Medicare inpatient admission policy or the "two-midnight rule." After the two midnight rule became effective, CMS initiated a probe and education process on a sample of claims per hospital to ensure that hospitals understand and fully comply with the policy. We also prohibited post-payment patient status


reviews for claims with dates of admission beginning on or after October 1, 2013. The Protecting Access to Medicare Act of 2014 requires CMS to continue the probe and education process and prohibits the Recovery Auditors from conducting post-payment patient status reviews of inpatient claims with dates of admission through March 31, 2015.

In the FY 2015 Inpatient Prospective Payment System (IPPS) proposed rule, we solicited public comments on the general concept of an alternative payment methodology for short-inpatient stays under the Medicare program and specifically how such a methodology might be designed (79 FR 28169). In the recently-released FY 2015 IPPS final rule (79 FR 49853), we noted the many comments submitted on the issue. We will take these comments into account in any potential future rulemaking. Although there was no consensus among the commenters, we look forward to continuing to actively work with hospitals and stakeholders to address the complex question of how to further improve payment policy for short inpatient hospital stays. We also continue to discuss and address these issues with the hospital community as concerns are raised.

We appreciate your interest in these important issues as we work towards our mutual goals of strengthening the Medicare program for beneficiaries, ensuring timely, appropriate payments to providers of services and suppliers, and providing a fair, impartial, and timely administrative review process for appellants. Please do not hesitate to contact us if you have any further thoughts or concerns. We will also provide this response to the co-signers of your letter.

Sincerely,

  
Marilyn Tavenner

  
Nancy J. Griswold

Enclosure

Enclosure

### **Recovery Audit Program Improvements**

The CMS is pleased to announce a number of changes to the Recovery Audit program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. These changes will be effective with the next Recovery Audit program contract awards.

- **More time for providers to engage with the Recovery Auditors.** Recovery Auditors will be required to wait 30 days (to allow for a discussion period) before sending the claim to the MAC for adjustment. Today, in some cases, providers must delay filing an appeal in order to initiate a discussion period with the RAC.
- **Improved customer service.** Recovery Auditors will be required to confirm receipt of a discussion request within three days.
- **More time before Recovery Auditors receive contingency fee if there is an appeal.** Recovery Auditors will be required to wait until the 2nd level appeal is exhausted before the CMS will pay them any contingency fee.
- **More claim diversity across a facility (e.g., inpatient, outpatient).** CMS is establishing revised additional document request (ADR) limits, so that they can be diversified across claim types.
- **Number of additional document requested during Recovery Auditors review proportional to denial rates.** CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.
- **Central point of contact for complaints/concerns about claim reviews.** CMS has established a Provider Relations Coordinator who can be reached at:
  - [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov) for Recovery Auditor review process concerns/suggestions
  - [MedicareMedicalReview@cms.hhs.gov](mailto:MedicareMedicalReview@cms.hhs.gov) or other contractor review process concerns/suggestions



DEPARTMENT OF HEALTH & HUMAN SERVICES

Administrator  
Centers for Medicare & Medicaid Services

Chief Administrative Law Judge  
Office of Medicare Hearing and Appeals

OCT 15 2014

The Honorable Charles Boustany, Jr.  
U.S. House of Representatives  
Washington, DC 20515

Dear Dr. Boustany:

Thank you for your letter concerning the Centers for Medicare & Medicaid Services' (CMS') Medicare Recovery Audit program and the backlog of claims at the Department of Health and Human Services' (HHS') Office of Medicare Hearings and Appeals (OMHA). We share your concern about delayed hearings for providers (as well as suppliers) who have appealed Qualified Independent Contractor (QIC) reconsiderations of Medicare claims denials to OMHA. We assure you that HHS has taken significant actions to address this challenge.

Congress established the Medicare Fee-for-Service (FFS) Recovery Audit program in 2009 to help ensure Medicare payments are being appropriately made. It is one of a number of tools CMS has to reduce improper payments and prevent fraud. In total, CMS manually reviews less than 0.3 percent of claims each year through programs such as the Recovery Audit program. Since full implementation in FY 2010 through the third quarter of FY 2014, the Recovery Audit program has recovered \$8.8 billion in improper payments. CMS uses the results of audits performed by the Recovery Auditors to identify potential vulnerabilities and take appropriate corrective actions to prevent future improper payments. As CMS has enhanced its efforts to prevent or recoup improper payments, however, provider and supplier appeals of payment denials have also increased.

We are always looking for ways to reduce the burden on providers, and we have received feedback on the Recovery Audit program from many stakeholders, including physicians and medical specialty societies. In response to this feedback, CMS has made a series of improvements to the program. Providers will have more time to engage with Recovery Auditors with a new 30-day discussion period that we anticipate will help resolve technical disputes. Recovery Auditors will receive their contingency fee only after the second level of appeal is exhausted. A more detailed description of these program improvements is enclosed. CMS is confident that these changes with the next Recovery Audit Program contract awards will result in a more effective and efficient program, including improved accuracy, decreased provider burden, and more transparency. Our goal is to balance our responsibilities to ensure all beneficiaries maintain access to care while providers and suppliers are paid promptly, and to ensure all Medicare claims are paid accurately, with a fair, impartial, and timely administrative review process for appellants.

It is important to note that CMS's Recovery Auditors apply the same Medicare policies and regulations as other Medicare contractors. These regulations and other policies, such as local coverage determinations, are open to public comments. We would encourage stakeholders to

participate in these feedback processes. Further, all review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For some reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both are aware of and approve of what the Recovery Auditors are reviewing and that they have the correct interpretation of the policies used in their audit methodologies. For other types of reviews, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

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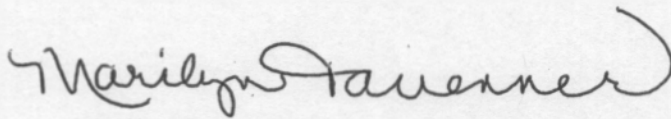
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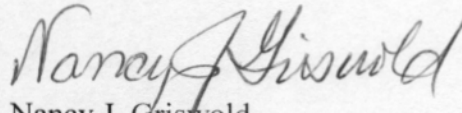
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We appreciate your interest in these important issues as we work towards our mutual goals of strengthening the Medicare program for beneficiaries, ensuring timely, appropriate payments to providers of services and suppliers, and providing a fair, impartial, and timely administrative review process for appellants. Please do not hesitate to contact us if you have any further thoughts or concerns. We will also provide this response to the co-signers of your letter.

Sincerely,



Marilyn Tavenner



Nancy J. Griswold

Enclosure



Enclosure

### **Recovery Audit Program Improvements**

The CMS is pleased to announce a number of changes to the Recovery Audit program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. These changes will be effective with the next Recovery Audit program contract awards.

- **More time for providers to engage with the Recovery Auditors.** Recovery Auditors will be required to wait 30 days (to allow for a discussion period) before sending the claim to the MAC for adjustment. Today, in some cases, providers must delay filing an appeal in order to initiate a discussion period with the RAC.
- **Improved customer service.** Recovery Auditors will be required to confirm receipt of a discussion request within three days.
- **More time before Recovery Auditors receive contingency fee if there is an appeal.** Recovery Auditors will be required to wait until the 2nd level appeal is exhausted before the CMS will pay them any contingency fee.
- **More claim diversity across a facility (e.g., inpatient, outpatient).** CMS is establishing revised additional document request (ADR) limits, so that they can be diversified across claim types.
- **Number of additional document requested during Recovery Auditors review proportional to denial rates.** CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.
- **Central point of contact for complaints/concerns about claim reviews.** CMS has established a Provider Relations Coordinator who can be reached at:
  - [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov) for Recovery Auditor review process concerns/suggestions
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Administrator  
Centers for Medicare & Medicaid Services

Chief Administrative Law Judge  
Office of Medicare Hearing and Appeals

OCT 15 2014

The Honorable Vern Buchanan  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter concerning the Centers for Medicare & Medicaid Services' (CMS') Medicare Recovery Audit program and the backlog of claims at the Department of Health and Human Services' (HHS') Office of Medicare Hearings and Appeals (OMHA). We share your concern about delayed hearings for providers (as well as suppliers) who have appealed Qualified Independent Contractor (QIC) reconsiderations of Medicare claims denials to OMHA. We assure you that HHS has taken significant actions to address this challenge.

Congress established the Medicare Fee-for-Service (FFS) Recovery Audit program in 2009 to help ensure Medicare payments are being appropriately made. It is one of a number of tools CMS has to reduce improper payments and prevent fraud. In total, CMS manually reviews less than 0.3 percent of claims each year through programs such as the Recovery Audit program. Since full implementation in FY 2010 through the third quarter of FY 2014, the Recovery Audit program has recovered \$8.8 billion in improper payments. CMS uses the results of audits performed by the Recovery Auditors to identify potential vulnerabilities and take appropriate corrective actions to prevent future improper payments. As CMS has enhanced its efforts to prevent or recoup improper payments, however, provider and supplier appeals of payment denials have also increased.

We are always looking for ways to reduce the burden on providers, and we have received feedback on the Recovery Audit program from many stakeholders, including physicians and medical specialty societies. In response to this feedback, CMS has made a series of improvements to the program. Providers will have more time to engage with Recovery Auditors with a new 30-day discussion period that we anticipate will help resolve technical disputes. Recovery Auditors will receive their contingency fee only after the second level of appeal is exhausted. A more detailed description of these program improvements is enclosed. CMS is confident that these changes with the next Recovery Audit Program contract awards will result in a more effective and efficient program, including improved accuracy, decreased provider burden, and more transparency. Our goal is to balance our responsibilities to ensure all beneficiaries maintain access to care while providers and suppliers are paid promptly, and to ensure all Medicare claims are paid accurately, with a fair, impartial, and timely administrative review process for appellants.

It is important to note that CMS's Recovery Auditors apply the same Medicare policies and regulations as other Medicare contractors. These regulations and other policies, such as local coverage determinations, are open to public comments. We would encourage stakeholders to

participate in these feedback processes. Further, all review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For some reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both are aware of and approve of what the Recovery Auditors are reviewing and that they have the correct interpretation of the policies used in their audit methodologies. For other types of reviews, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

The CMS has implemented measures designed to reduce the backlog of provider appeals and to reduce the number of appeals that reach the third level of appeal at OMHA (the Administrative Law Judge (ALJ) level). On August 29, 2014, CMS announced a new effort to address the **current** backlog of appeals, available for those appeals where the claim was denied due to incorrect inpatient status with dates of admission before October 1, 2013. Incorrect inpatient status denials occur when the physician admits a Medicare beneficiary as inpatient while the medical record supports the provision of care in a hospital outpatient or other non-hospital based setting. For these cases, CMS is offering an administrative agreement to hospitals willing to withdraw pending appeals in exchange for partial payment (68 percent) of eligible inpatient claims. The deadline for hospitals to submit settlement requests to CMS is October 31, 2014. More information is available at: <http://go.cms.gov/InpatientHospitalReview>. CMS also plans to expand a prior authorization demonstration for Power Mobility Devices (PMD), which helps ensure proper payment while reducing PMD claim denials and appeals.

The OMHA has also taken steps to operate more efficiently in the face of increased provider appeals. Despite relatively stable funding levels over the years, OMHA's ALJs were previously able to handle a steadily growing workload by increasing productivity and using resources more efficiently. Indeed, OMHA judges have doubled their productivity rate over the last three years. To reduce the current backlog, OMHA recently announced that it is offering two new options for appellants to resolve their pending claim appeals. The first facilitates resolution of large numbers of claims based upon resolution of a statistically valid sample. The second uses alternative dispute resolution techniques during a facilitated settlement conference. More information can be found at: <http://www.hhs.gov/omha/>. OMHA has also increased its adjudicatory capacity by adding 10 new ALJs at the beginning of August. Six of these new ALJs reported to a new OMHA field office in Kansas City, Missouri. This is the first new field office since OMHA opened its doors in July 2005. It marks a significant step in the future expansion of the agency in order to meet increasing demands.

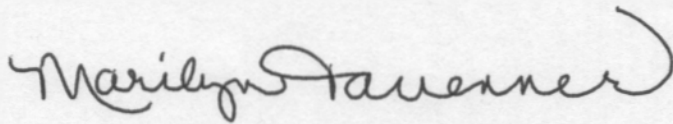
We appreciate your comments about the implementation of the Medicare inpatient admission policy or the "two-midnight rule." After the two midnight rule became effective, CMS initiated a probe and education process on a sample of claims per hospital to ensure that hospitals understand and fully comply with the policy. We also prohibited post-payment patient status

reviews for claims with dates of admission beginning on or after October 1, 2013. The Protecting Access to Medicare Act of 2014 requires CMS to continue the probe and education process and prohibits the Recovery Auditors from conducting post-payment patient status reviews of inpatient claims with dates of admission through March 31, 2015.

In the FY 2015 Inpatient Prospective Payment System (IPPS) proposed rule, we solicited public comments on the general concept of an alternative payment methodology for short-inpatient stays under the Medicare program and specifically how such a methodology might be designed (79 FR 28169). In the recently-released FY 2015 IPPS final rule (79 FR 49853), we noted the many comments submitted on the issue. We will take these comments into account in any potential future rulemaking. Although there was no consensus among the commenters, we look forward to continuing to actively work with hospitals and stakeholders to address the complex question of how to further improve payment policy for short inpatient hospital stays. We also continue to discuss and address these issues with the hospital community as concerns are raised.

We appreciate your interest in these important issues as we work towards our mutual goals of strengthening the Medicare program for beneficiaries, ensuring timely, appropriate payments to providers of services and suppliers, and providing a fair, impartial, and timely administrative review process for appellants. Please do not hesitate to contact us if you have any further thoughts or concerns. We will also provide this response to the co-signers of your letter.

Sincerely,



Marilyn Tavenner



Nancy J. Griswold

Enclosure

Enclosure

### **Recovery Audit Program Improvements**

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Congress of the United States  
Washington, DC 20515

August 5, 2014

The Honorable Marilyn Tavenner  
Administrator  
Center for Medicare & Medicaid Services  
200 Independence Avenue SW  
Washington, DC 20201

RECEIVED

AUG 11 2014

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

Dear Administrator Tavenner:

We write today to express our concern regarding the Center for Medicare and Medicaid Service's management and oversight of the Recovery Audit Contractor (RAC) program, as well as the current backlog of appeals at the Administrative Law Judge (ALJ) level. While we appreciate the administration's efforts to ensure the appropriate use of taxpayer dollars and prevent improper payments within the Medicare and Medicaid programs, we are concerned that the RAC program has had unintended consequences for both providers and patients.

The RAC program, first authorized as a demonstration program and expanded nationally in 2010, is responsible for reviewing, auditing, and identifying improper payments to Medicare providers. There are five distinct levels of appeals afforded to providers in the Medicare program. Between 2011 and 2013, the number of appeals at the ALJ, or the third level of appeals, increased from 92,000 to 460,000 claims – a growth of 500%. At the beginning of 2014, the Office of Medicare Hearings & Appeals (OMHA) suspended the assignment of new appeals at the ALJ level in reaction to this exponential growth in appeals. The average processing time of an appeal at the ALJ level for fiscal year 2014 is now 387 days, far greater than the 90-day time frame outlined in statute.<sup>1</sup> While we appreciate that CMS has recognized there is a problem and is actively working to reform both the audit program and the appeals process, we urge the administration to keep the following in mind as it advances this effort.

When RACs began to audit hospitals in 2009, CMS recognized a problem in the determination between inpatient and outpatient status. It took CMS four years, however, to offer clarification in the form of the two-midnight rule. Sadly, this has only exacerbated the problem. Variation in interpretation of inpatient admission standards is caused by CMS's failure to ensure that the RAC audit guidelines are made public or are specifically approved by CMS as accurate interpretations of Medicare policy and adherence to accepted medical practice before these guidelines are utilized in any audit. The two-midnight rule failed to clarify the determination for inpatient admissions and raises just as many risks for excessive audits as before. In order to ameliorate

<sup>1</sup> U.S. Department of Health & Human Services, *Office of Medicare Hearings and Appeals (OMHA)*. Accessed at [http://www.hhs.gov/omha/important\\_notice\\_regarding\\_adjudication\\_timeframes.html](http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html) on July 30, 2014.

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confusion over short inpatient stays, we encourage CMS to consider site-neutral payments as a solution to this problem.

We also urge CMS to increase the level of transparency in the audit process for hospitals and RACs. Any and all criteria used by RACs to make medically complex judgments should be made public so that consensus can be achieved as to whether the RAC review guideline correctly interprets Medicare policy. The expansive growth in appeals coupled by the overturn rate of 72% of inpatient hospital short stays at the ALJ level seems representative of confusion, rather than improper payments.<sup>2</sup> By bringing greater clarity to the program at the outset of the audit process, fewer unnecessary audits will be performed, reducing pressure on the appeals system to adjudicate disagreements over policy interpretations and reducing the undue and unintended burden on healthcare providers seeking to achieve compliance.

We ask that CMS consult stakeholders, physicians, and the medical specialty societies in developing further guidelines or criteria under which medically complex judgments must be made to evaluate claims. Ensuring expert input into the guidelines or “review methodologies” that RACs use would improve the quality of the RAC audits and reduce unnecessary audits. CMS should place immediate priority on review guidelines for certain types of short-term inpatient stays where such expert consensus is sorely needed, such as those associated with cardiac procedures which, according to CMS’s 2012 RAC report to Congress, have received the most audit focus from RACs.<sup>3</sup>

We encourage CMS to bring greater fairness to the program, both within the audit program and the appeals process. For example, the administration has halted any new appeals at the ALJ level, the first level appeals open to providers outside of the Medicare program, and yet CMS has not restricted the RACs ability to continue to audit and recover payments. We hear from our constituent stakeholders numerous examples of overly technical application of the rules that are easily overturned on appeal (missing physician signatures that can be easily located in the medical record) and of RACs reaching inconsistent decisions on two similar inpatient claims. We encourage CMS to ensure that there is some mechanism to resolve technical disputes and provide consistency in decision making, without adding to the overburdened appeals system.

Finally, it is imperative to remain thoughtful of the unintended consequence these and other programs have on Medicare beneficiaries. We hear from district stakeholders that the cost of compliance takes away resources that could otherwise be utilized for patient care. Most providers have had significant experience with Medicare and Medicaid audits, and RAC audits are unique in diverting significant amounts of manpower and operational resources away from patient care in order to respond to record requests and

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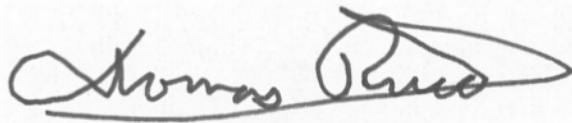
<sup>2</sup> OIG HHS, Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals. Accessed at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf> on July 30, 2014.

<sup>3</sup> Centers for Medicare & Medicaid Services, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012*. Accessed at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012\\_013114.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf) on July 30, 2014.

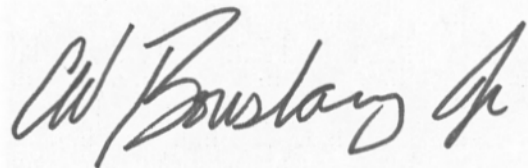
pursue appeals of improper denials. As with all integrity programs in Medicare, we understand that there are limited resources and CMS must constantly review how to apply those resources effectively. We ask CMS to encourage RACs to audit those Medicare programs with historically higher error rates reflecting improper payments, instead of those programs with the greatest potential monetary reward.<sup>4</sup>

We thank you for your consideration of our request and remain committed to working with you to improve this program.

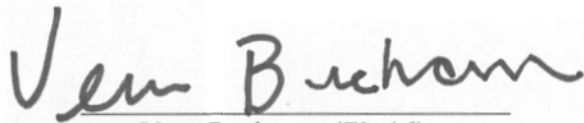
Sincerely,



Tom Price, MD (GA-06)  
Member of Congress



Charles Boustany, Jr., MD (LA-03)  
Member of Congress



Vern Buchanan (FL-16)  
Member of Congress

CC: Judge Nancy Griswold, Office of Medicare Hearings & Appeals

<sup>4</sup> Centers for Medicare & Medicaid Services. *Comprehensive Error Rate Testing (CERT)*. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html?redirect=/ccrt> on July 30, 2014.



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Price:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

- **Delayed Start Date:** In order to allow participant hospitals more time to prepare for success under the model, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016 performance period start date.
- **Financial Protections:** In response to comments from the public, we have finalized additional policies to phase in financial responsibility for hospitals participating in the CJR Model. Hospitals will have no repayment responsibility in Performance Year (PY) 1, and repayment responsibility will be phased in gradually over the course of PYs 2 and 3. The final rule also includes stop-loss protections limiting the amount of financial responsibility for all participant hospitals, with additional financial protection for certain types of participant hospitals, such as rural hospitals or sole community hospitals. The stop-loss protections in the final rule also follow a more gradual implementation timeline than those in the proposed rule, with a stop-loss limit of 5 percent in PY 2, 10 percent in PY Year 3, and 20 percent in PYs 4 and 5.
- **Data Sharing:** The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide



participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

- Utilizing Existing Payment Processes: The usual Medicare Fee-or-Service claims submission processes will continue throughout the model. In other words, providers and suppliers furnishing services during the episode of care will submit a claim to Medicare and receive payment as they normally would.
- Accounting for Complex Patients: The CJR Model has been designed to include appropriate safeguards for complex patients, including a payment method that protects hospitals from the risk of high payment episodes. In addition, in response to commenters' requests to modify our payment structure to account for more complex patients, we finalized a risk stratification method that will set different prices for beneficiaries undergoing lower joint replacement procedures due to hip fracture.

We have also finalized the following proposals to protect beneficiaries: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; and continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (and other applicable privacy laws; and patient notification by providers and suppliers. Further, beneficiaries retain their freedom of choice to choose services and providers, and all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's Quality Improvement Organization. If concerns are identified, the Centers for Medicare & Medicaid Services can initiate audits and corrective action under existing authority.

Participating hospitals meeting certain criteria, such as rural hospitals, Medicare-dependent hospitals, and sole community hospitals, will be afforded additional financial protections for the duration of the model. We will implement a stop-loss limit of 3 percent of episode payments for these categories of hospitals in PY 2 and a stop-loss limit of 5 percent of episode payments for PYs 3 through 5.

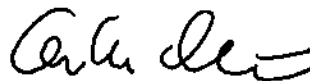
Under existing bundled payment models, in which providers across the continuum of care share accountability for the clinical management and total cost of an episode of care, the capacity to share information electronically across disparate provider systems can be important for delivering efficient, safe, high-quality care. With respect to the utilization of electronic health records (EHRs) by participant hospitals and their clinical partners in the CJR Model, we received comments from the public on an EHR usage measure in the proposed rule. We appreciate the insights and concerns expressed around utilizing a measure of health information technology tied to participation in EHR incentive programs. We will consider these comments as we assess any future measures for the CJR model.

Finally, we note that while participant hospitals will be the episode initiators under this model and the entities financially responsible, the model will allow participant hospitals to enter into

financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Our experience with other episode payment models has demonstrated that many providers view these arrangements to be useful mechanisms in better aligning financial incentives between different provider types. That said, we believe it is necessary to have a limit on the maximum amount a collaborating provider or supplier could earn through these arrangements to ensure that distributions are not made for purposes other than improving the quality and value of care to beneficiaries. In addition to sharing savings, participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain incentives to advance the clinical goals of their care, under certain conditions.

Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. 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



DEC - 2 2015

*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 interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

- **Delayed Start Date:** In order to allow participant hospitals more time to prepare for success under the model, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016 performance period start date.
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participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

- Utilizing Existing Payment Processes: The usual Medicare Fee-or-Service claims submission processes will continue throughout the model. In other words, providers and suppliers furnishing services during the episode of care will submit a claim to Medicare and receive payment as they normally would.
- Accounting for Complex Patients: The CJR Model has been designed to include appropriate safeguards for complex patients, including a payment method that protects hospitals from the risk of high payment episodes. In addition, in response to commenters' requests to modify our payment structure to account for more complex patients, we finalized a risk stratification method that will set different prices for beneficiaries undergoing lower joint replacement procedures due to hip fracture.

We have also finalized the following proposals to protect beneficiaries: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; and continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (and other applicable privacy laws; and patient notification by providers and suppliers. Further, beneficiaries retain their freedom of choice to choose services and providers, and all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's Quality Improvement Organization. If concerns are identified, the Centers for Medicare & Medicaid Services can initiate audits and corrective action under existing authority.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Charles Boustany M.D.  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Boustany:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Participating hospitals meeting certain criteria, such as rural hospitals, Medicare-dependent hospitals, and sole community hospitals, will be afforded additional financial protections for the duration of the model. We will implement a stop-loss limit of 3 percent of episode payments for these categories of hospitals in PY 2 and a stop-loss limit of 5 percent of episode payments for PYs 3 through 5.

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Page 3 - The Honorable Charles Boustany M.D.

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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

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Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative DesJarlais:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Joseph Heck D.O.  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Heck:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Paul Gosar DDS  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Gosar:

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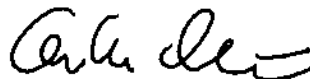
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*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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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Brian Babin DDS  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Babin:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Brad Wenstrup DPM  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Wenstrup:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Ruben Hinojosa  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Hinojosa:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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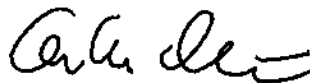
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Nunes:

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Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Young:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Renacci:

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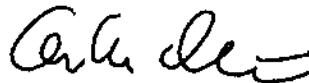
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Smith:

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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Vern Buchanan  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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- **Data Sharing:** The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide

participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

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- Accounting for Complex Patients: The CJR Model has been designed to include appropriate safeguards for complex patients, including a payment method that protects hospitals from the risk of high payment episodes. In addition, in response to commenters' requests to modify our payment structure to account for more complex patients, we finalized a risk stratification method that will set different prices for beneficiaries undergoing lower joint replacement procedures due to hip fracture.

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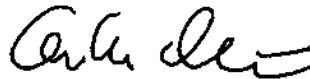
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Sincerely,



Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Walter Jones  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Jones:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Sincerely,



Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Meadows:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Andrew M. Slavitt  
Acting Administrator

~~DEC - 2 2015~~*Administrator*

Washington, DC 20201

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

Dear Representative Blackburn:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Pete Session  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Session:

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Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Kurt Schrader  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Schrader:

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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Wagner:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

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Sincerely,



Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Earl "Buddy" Carter  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Carter:

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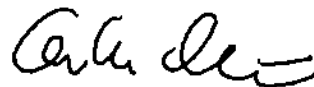
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Scott:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Pete Olson  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Olson:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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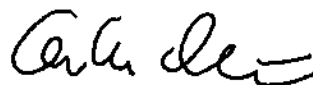
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Westmoreland:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Allen:

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Sincerely,



Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Flores:

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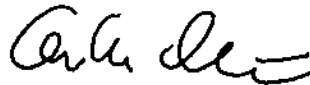
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Sincerely,



Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Barry Loudermilk  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Loudermilk:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Chabot:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Louie Gohmert  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Gohmert:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Mac Thornberry  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Thornberry:

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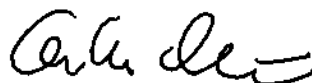
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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Mica:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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- **Data Sharing:** The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide

participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

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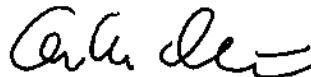
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Coffman:

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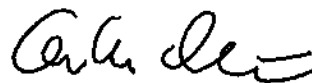
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Rice:

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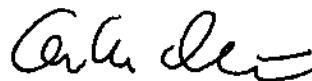
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Dina Titus  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Titus:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Duncan:

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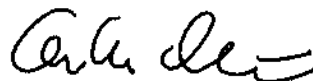
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DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Gary Palmer  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Palmer:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Jackie Walorski  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Walorski:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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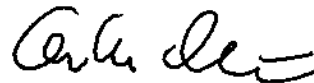
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Daniel Webster  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Webster:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Ryan Costello  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Costello:

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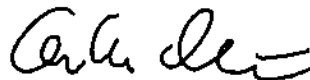
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Ros-Lehtinen:

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Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Posey:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Brady:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

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Sincerely,



Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Kelly:

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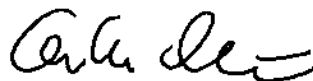
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable John Fleming M.D.  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Fleming:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Cohen:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Westerman:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Ellmers:

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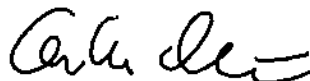
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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Jody Hice  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Hice:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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- **Data Sharing:** The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide



participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Gus Bilirakis  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Bilirakis:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Jeb Hensarling  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Hensarling:

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Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Carlos Curbelo  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Curbelo:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Bob Goodlatte  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Goodlatte:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Tiberi:

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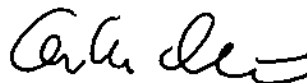
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Lance:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Barletta:

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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*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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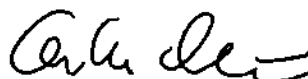
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Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Scott:

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Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Benishek:

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

Andrew M. Slavitt  
Acting Administrator





DEC - 2 2015

*Administrator*  
Washington, DC 20201

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

Dear Representative Jenkins:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

- Delayed Start Date: In order to allow participant hospitals more time to prepare for success under the model, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016 performance period start date.
- Financial Protections: In response to comments from the public, we have finalized additional policies to phase in financial responsibility for hospitals participating in the CJR Model. Hospitals will have no repayment responsibility in Performance Year (PY) 1, and repayment responsibility will be phased in gradually over the course of PYs 2 and 3. The final rule also includes stop-loss protections limiting the amount of financial responsibility for all participant hospitals, with additional financial protection for certain types of participant hospitals, such as rural hospitals or sole community hospitals. The stop-loss protections in the final rule also follow a more gradual implementation timeline than those in the proposed rule, with a stop-loss limit of 5 percent in PY 2, 10 percent in PY Year 3, and 20 percent in PYs 4 and 5.
- Data Sharing: The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide

participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

- Utilizing Existing Payment Processes: The usual Medicare Fee-or-Service claims submission processes will continue throughout the model. In other words, providers and suppliers furnishing services during the episode of care will submit a claim to Medicare and receive payment as they normally would.
- Accounting for Complex Patients: The CJR Model has been designed to include appropriate safeguards for complex patients, including a payment method that protects hospitals from the risk of high payment episodes. In addition, in response to commenters' requests to modify our payment structure to account for more complex patients, we finalized a risk stratification method that will set different prices for beneficiaries undergoing lower joint replacement procedures due to hip fracture.

We have also finalized the following proposals to protect beneficiaries: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; and continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (and other applicable privacy laws; and patient notification by providers and suppliers. Further, beneficiaries retain their freedom of choice to choose services and providers, and all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's Quality Improvement Organization. If concerns are identified, the Centers for Medicare & Medicaid Services can initiate audits and corrective action under existing authority.

Participating hospitals meeting certain criteria, such as rural hospitals, Medicare-dependent hospitals, and sole community hospitals, will be afforded additional financial protections for the duration of the model. We will implement a stop-loss limit of 3 percent of episode payments for these categories of hospitals in PY 2 and a stop-loss limit of 5 percent of episode payments for PYs 3 through 5.

Under existing bundled payment models, in which providers across the continuum of care share accountability for the clinical management and total cost of an episode of care, the capacity to share information electronically across disparate provider systems can be important for delivering efficient, safe, high-quality care. With respect to the utilization of electronic health records (EHRs) by participant hospitals and their clinical partners in the CJR Model, we received comments from the public on an EHR usage measure in the proposed rule. We appreciate the insights and concerns expressed around utilizing a measure of health information technology tied to participation in EHR incentive programs. We will consider these comments as we assess any future measures for the CJR model.

Finally, we note that while participant hospitals will be the episode initiators under this model and the entities financially responsible, the model will allow participant hospitals to enter into

financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Our experience with other episode payment models has demonstrated that many providers view these arrangements to be useful mechanisms in better aligning financial incentives between different provider types. That said, we believe it is necessary to have a limit on the maximum amount a collaborating provider or supplier could earn through these arrangements to ensure that distributions are not made for purposes other than improving the quality and value of care to beneficiaries. In addition to sharing savings, participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain incentives to advance the clinical goals of their care, under certain conditions.

Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

Sincerely,



Andrew M. Slavitt  
Acting Administrator



DEC - 2 2015

*Administrator*  
Washington, DC 20201

The Honorable Terri Sewell  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Sewell:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

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participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

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Under existing bundled payment models, in which providers across the continuum of care share accountability for the clinical management and total cost of an episode of care, the capacity to share information electronically across disparate provider systems can be important for delivering efficient, safe, high-quality care. With respect to the utilization of electronic health records (EHRs) by participant hospitals and their clinical partners in the CJR Model, we received comments from the public on an EHR usage measure in the proposed rule. We appreciate the insights and concerns expressed around utilizing a measure of health information technology tied to participation in EHR incentive programs. We will consider these comments as we assess any future measures for the CJR model.

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Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. 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

September 21, 2015

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

Patrick Conway, M.D., MSc  
Deputy Administrator, Innovation & Quality  
Chief Medical Officer  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Slavitt and Dr. Conway:

CMS recently proposed the Comprehensive Care for Joint Replacement Model (CCJR), a new episode-based payment model for lower extremity joint replacement (LEJR) that would apply to 75 Metropolitan Statistical Areas (MSA's) for five years. The CCJR proposed payment model represents a significant change for beneficiaries and providers because it constitutes the first mandatory Medicare episode payment model promulgated under CMS' CMMI authority. Other CMS proposed models, including the Bundled Payments for Care Improvement (BPCI) on which the CCJR model was based, have all been voluntary. Given this substantial change for Medicare beneficiaries and providers, we raise certain questions and ask that you delay the implementation of the CCJR payment model for at least one year.

HHS has a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as Hospital Value Based Purchasing. To be sure, increasing value by means of improved outcomes and reduced cost is a goal that we all share. As a result, the questions below relate not to the goal itself but, rather, how the Centers for Medicare and Medicaid Services (CMS) seeks to achieve it.

1. We recognize the uniquely positive influence that patient choice has in achieving quality, responsiveness, effectiveness, and efficiency of healthcare services. Systems that foster patient choice have proven to work, whereas those that supplant patient choice with centralized control have often led to shortages, rationing, and poor outcomes. If it ultimately places post-acute care (PAC) funding with hospital control, the CCJR model would likely create a strong incentive for hospitals to acquire post-acute care facilities and orthopedic surgery practices, or preclude independent practices from performing surgeries at the hospital. There is a considerable body of evidence suggesting that healthcare market consolidation can have deleterious effects on patients, providers, and taxpayers.<sup>1</sup> It also appears likely that hospitals would be compelled to

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<sup>1</sup> Between 1998 and 2012, there were 1,113 mergers and acquisitions involving a total of 2,277 hospitals. Mergers have nearly doubled in recent years. There were 95 hospital mergers in 2014, 98 in 2013, and 95 in 2012. Compare that with

restrict the provision of additional services by Medicare beneficiaries' physicians in order to mitigate the risk that hospitals will face under the CCJR program. What safeguards are incorporated into the proposed CCJR model, and are under consideration in any possible future iteration, that would guard against hospital-driven vertical integration or other forms of market consolidation that could lead to higher costs? Consequently, what protections are incorporated into the proposed CCJR model to maintain a patient's freedom to choose their provider, course of treatment, and medical services?

2. We are concerned that patients requiring higher-cost complex surgeries (such as hip fractures and ankle replacement procedures) or who suffer from multiple chronic conditions may find it more difficult to find hospitals willing to serve them, since the greater risk of complications or the higher level of post-acute care associated with their condition would be logically viewed by hospitals as increasing their risk under the proposed CCJR model. Additionally, since the CCJR model excludes "non-elective" joint replacement surgeries (many of which involve complex hip fractures) from its quality framework, but otherwise maintains such cases for "target price" and episode expenditure purposes, this could potentially place too much emphasis on the cost of these vulnerable patients' post-acute care without adequate consideration of their outcomes and the quality of care they receive. What safeguards are incorporated into the proposed CCJR model to ensure that patients with complex surgeries or chronic conditions would have access to the full spectrum of hospitals, physicians, and post-acute care providers under CCJR that they are able to access today?
3. Small and rural hospitals are a crucial resource for numerous communities. The risk placed on hospitals by CCJR, as well as the oversight and administrative responsibilities that hospitals would have to bear for 90 days post-discharge may be so burdensome that small and rural hospitals may have little option other than to be subsumed into larger systems or refrain from offering lower extremity joint replacement surgeries. What safeguards are incorporated into the proposed CCJR program to address the specific needs and circumstances of small and rural hospitals?

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50 mergers in 2005, and 54 in 2006. American Hospital Association, *Trendwatch Chartbook 2012: Trends Affecting Hospitals and Health Systems*, <http://www.aha.org/research/reports/tw/chartbook/index.shtml>. See also: Glenn Melnick and Emmett Keeler, "The Effects of Multi-Hospital Systems on Hospital Prices," *Journal of Health Economics*, Vol. 26 (2007), pp. 400–413. See also: Martin Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" National Bureau of Economic Research *Working Paper* No. 12301, June 2006, <http://www.nber.org/papers/w12301.pdf>. In 2005, only a quarter of physician medical practices were owned by hospitals. By 2008, the majority of physician practices were hospital owned. Gardiner Harris, "More Doctors Giving Up Private Practices," *The New York Times*, March 25, 2010. (See also House Committee on Ways and Means, Hearing on Health Care Industry Consolidation, September 9, 2011 and House Committee on Small Business, Subcommittee on Investigations, Oversight, and Regulations, "Health Care Realignment and Regulation: The Demise of Small and Solo Medical Practices?" July 19, 2012.) In 2014, the share of doctors who have an ownership stake in their practice was estimated to be down to about one-third, and only 2 percent of newly licensed physicians were seeking a solo practice. David Rotham, "Hospital Networks Need a Hippocratic Oath," *The New York Times*, March 6, 2014. See also: Xu T, Wu AW, Makary MA. The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price. *JAMA*. Published online August 13, 2015.




4. This CCJR model requires sophisticated coordination of care that will demand additional providers within the post-acute setting to collaborate with hospitals to define and monitor a patient's care plan.<sup>2</sup> The CCJR proposed rule indicates that forcing post-acute care providers to invest in Electronic Health Records (EHRs) will accomplish the needed coordination, as hospitals that rely on post-acute care providers without EHRs may not be eligible for reconciliation payments in the future. How would this mandatory approach within the CCJR model prevent forced relationships between providers based on the meaningful use of EHRs, rather than allowing these choices to be based on who provides the best quality of care, keeps patients the safest, and does the best job of coordinating with the hospital and other providers?
  
5. The total amount of gainsharing payments for a calendar year paid to an individual physician, nonphysician practitioner, or physician group practice who is a CCJR collaborator cannot exceed a cap equal to 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital's CCJR beneficiaries during a CCJR episode by that physician, non-physician practitioner, or members of the physician group practice. Why are you limiting gainsharing payments to providers who will be responsible for much of the care-redesign required in this model? Additionally, why are post-acute care providers not meaningfully included in the CCJR bundle to ensure quality care is provided over the entire continuum of care?

In light of the January 1, 2016 effective date proposed by the Agency, we request your response to these questions no later than October 1, 2015. The CMS proposal represents a significant change to our healthcare delivery system which could have a negative impact on patient choice, access and quality. Given the fact that the proposed rule will not be finalized until almost the year's end, it will give physicians, hospitals and post-acute providers little or no time to prepare for this abrupt shift in payment for these high-volume procedures and the changes in care delivery that they will require. As a result, we ask that you seriously reconsider the CCJR payment model. At a minimum, we ask that you delay the implementation of the CCJR payment model for at least one year.

Yours truly,

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<sup>2</sup> CMS assumes that hospitals will enter sharing arrangements with post-acute care providers. See pg. 41297 of the CMS proposed CCJR rule.



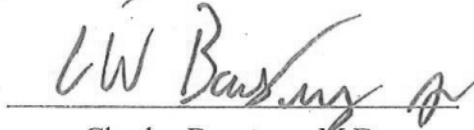
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Tom Price, M.D.



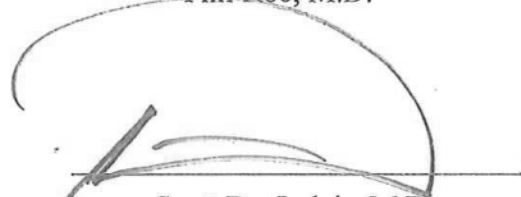
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Phil Roe, M.D.



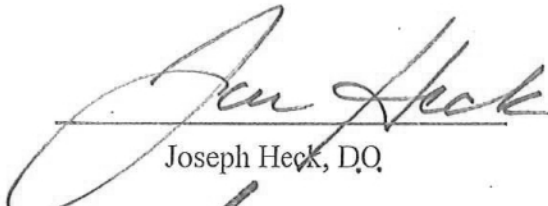
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Charles Boustany, M.D.



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Scott DesJarlais, M.D.




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Joseph Heck, D.O.




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Paul Gosar, DDS




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Andy Harris, M.D.



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Brian Babin, DDS



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Brad Wenstrup, DPM



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Rubén Hinojosa



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Devin Nunes



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Todd Young



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Jim Renacci



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Jason Smith

Vern Buchanan

Vern Buchanan

Earl L. 'Buddy' Carter

Earl "Buddy" Carter

Walter B. Jones

Walter Jones

Austin Scott

Austin Scott

Mark Meadows

Mark Meadows

Pete Olson

Pete Olson

Martina Blackburn

Martina Blackburn

Lynn Westmoreland

Lynn Westmoreland

Pete Sessions

Pete Sessions

Rick Allen

Rick Allen

Kurt Schrader

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Bill Flores

Bill Flores

Ann Wagner

Ann Wagner

Barry Loudermilk

Barry Loudermilk




Steve Chabot



John Duncan



Louie Gohmert



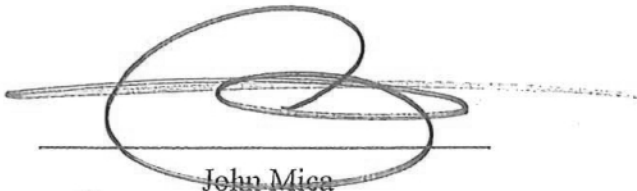
Gary Palmer



Mac Thornberry



Jackie Walorski



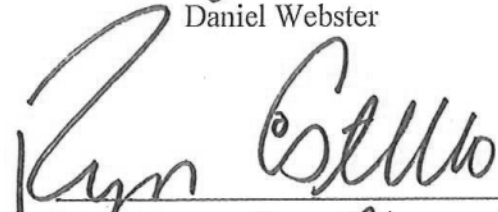
John Mica



Daniel Webster



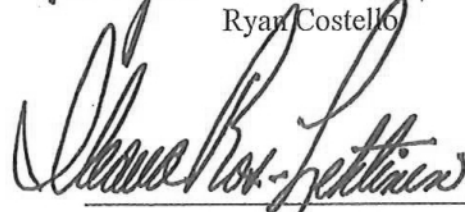
Mike Coffman



Ryan Costello



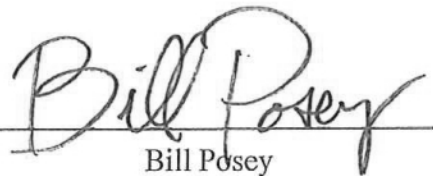
Tom Rice



Ileana Ros-Lehtinen



Dina Titus

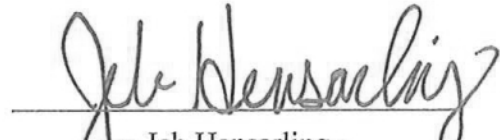



Bill Posey

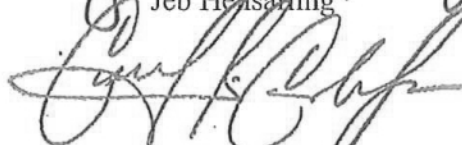
  
Kevin Brady


  
Gus Bilirakis

  
Mike Kelly

  
Jeb Hensarling

  
John Fleming, MD

  
Carlos Curbelo

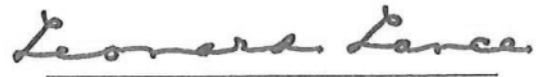
  
Steve Cohen

  
Bob Goodlatte

  
Bruce Westerman


  
Pat Tiberi

  
Renee Ellmers

  
Leonard Lance

  
Jody Hice


  
Lou Barletta

  
Larry Bucshon, M.D.

  
Lynn Jenkins

  
David Scott

  
Terri Sewell

  
Dan Benishek, M.D.



JAN - 4 2017

*Administrator*  
Washington, DC 20201

The Honorable Tom Price, M.D.  
U.S. House of Representatives  
Washington, DC 20015

Dear Representative Price:

Thank you for your letter regarding the Center for Medicare and Medicaid Innovation (Innovation Center) and its authority to test innovative payment and service delivery models. We share your goal of moving to higher quality, more value-based care for our nation's seniors.

The Innovation Center's mission is to test innovative payment and service delivery models designed to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. To be successful in this mission, the Innovation Center must remain nimble and flexible, capable of not only developing new models, but also of improving upon models quickly based on feedback from beneficiaries, doctors and other clinicians, and other stakeholders. Several ideas for Innovation Center models have come directly from physicians and other clinicians, and the clinicians in Innovation Center models help shape and refine the models through feedback.

The Innovation Center is essential to the implementation of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. To move towards paying for value, MACRA directs the Secretary of the Department of Health and Human Services (HHS) to establish a new approach to payment called the Quality Payment Program. The Quality Payment Program allows eligible clinicians participating in Advanced Alternative Payment Models (Advanced APMs) at certain threshold levels to receive an incentive payment, and the Innovation Center is creating as many opportunities for eligible clinicians to participate in Advanced APMs as possible.

The Innovation Center has launched over 35 payment and service delivery models, and the vast majority of the Innovation Center models are voluntary. But, there are certain promising potential models that are difficult or impossible to test on a voluntary basis. For example, some potential models are unlikely to have a positive impact on quality and cost unless they are applied uniformly and equitably to eligible providers or suppliers in a geographic area, and in some potential models requiring participation is necessary to control for potential bias in evaluation results. In these circumstances, we propose the model design and propose requiring participation through notice and comment rulemaking, and we consider public comments carefully before each rule is finalized. Only the Comprehensive Care for Joint Replacement (CJR) Model, the Home Health Value-Based Purchasing Model, and the recently finalized models in the Advancing Care Coordination through Episode Payment Models Final Rule require participation by all eligible providers or suppliers in a given geographic area. The remaining model tests have voluntary participation.


Preserving beneficiary rights and beneficiary freedom of choice are bedrock considerations in the design and implementation of all Innovation Center models. Under all current Innovation Center models, beneficiaries retain access to all covered Medicare, Medicaid, and CHIP services. Beneficiaries also retain access to claims and appeals processes under the Innovation Center's existing models. In some cases, models include certain increased beneficiary protections. We also implement robust monitoring plans for each model test to protect beneficiaries by detecting any potential issues.

In addition, no Innovation Center model dictates the practice of medicine. Physicians and other clinicians are encouraged to innovate and improve care as part of Innovation Center models. We engage extensively with stakeholders, and we take such feedback into consideration before model designs are finalized. This engagement continues after models have launched, as we regularly refine approaches in response to stakeholder feedback. As an example, in response to stakeholder input and feedback, the Innovation Center included a 3-day Skilled Nursing Facility Rule Waiver in the Pioneer Accountable Care Organization (ACO) Model and incorporated that improvement in the Next Generation ACO Model.

All Innovation Center models are designed to further our mission to preserve or enhance quality of care while reducing expenditures. For instance, in the CJR Model, payment is tied to quality using a composite score assigned each year based on the participant hospital's performance and improvement on rates of complications associated with joint replacement, along with patient-reported satisfaction. Participant hospitals that voluntarily submit performance data on patient-reported outcomes receive additional points for their composite quality score, which can result in higher payment. Linking payment to quality of care in this way is typical, both in Innovation Center models and in Medicare programs such as the Shared Savings Program. We believe it is essential to simultaneously pursue both reduced spending and improved quality, consistent with our authorizing statute. Results from some Innovation Center models, such as the Pioneer ACO Model, have shown the Innovation Center's success in generating savings while improving the quality of care.<sup>1</sup>

We appreciate your interest in the Innovation Center's design and testing of models and their role in moving toward the goal of strengthening the Medicare, Medicaid, and CHIP programs for all beneficiaries. We look forward to further engaging with you and your colleagues, physicians, patients, states, and other stakeholders to shape the future of the Innovation Center. I will provide a copy of this response to the co-signers of your letter.

Sincerely,



Andrew M. Slavitt  
Acting Administrator

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<sup>1</sup> See Medicare Accountable Care Organizations 2015 Performance Year Quality and Financial Results, Aug. 25, 2016, Centers for Medicare & Medicaid Services, <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-08-25.html>





JAN - 4 2017

*Administrator*

Washington, DC 20201

The Honorable Charles W. Boustany, Jr., M.D.  
U.S. House of Representatives  
Washington, DC 20015

Dear Representative Boustany, Jr.:

Thank you for your letter regarding the Center for Medicare and Medicaid Innovation (Innovation Center) and its authority to test innovative payment and service delivery models. We share your goal of moving to higher quality, more value-based care for our nation's seniors.

The Innovation Center's mission is to test innovative payment and service delivery models designed to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. To be successful in this mission, the Innovation Center must remain nimble and flexible, capable of not only developing new models, but also of improving upon models quickly based on feedback from beneficiaries, doctors and other clinicians, and other stakeholders. Several ideas for Innovation Center models have come directly from physicians and other clinicians, and the clinicians in Innovation Center models help shape and refine the models through feedback.

The Innovation Center is essential to the implementation of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. To move towards paying for value, MACRA directs the Secretary of the Department of Health and Human Services (HHS) to establish a new approach to payment called the Quality Payment Program. The Quality Payment Program allows eligible clinicians participating in Advanced Alternative Payment Models (Advanced APMs) at certain threshold levels to receive an incentive payment, and the Innovation Center is creating as many opportunities for eligible clinicians to participate in Advanced APMs as possible.

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**Congress of the United States**  
**Washington, DC 20515**

September 29, 2016

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

Patrick Conway, M.D., MSc  
Deputy Administrator, Innovation & Quality  
Chief Medical Officer  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Slavitt and Dr. Conway,

The Center for Medicare and Medicaid Innovation (CMMI) is charged with testing and evaluating voluntary healthcare payment and service delivery models with the intent of increasing quality and efficiency while reducing program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).<sup>1</sup> However, as evidenced by three recently proposed mandatory models, CMMI has exceeded its authority, failed to engage stakeholders, and has upset the balance of power between the legislative and executive branches.<sup>2</sup> What makes these proposals even more disconcerting is their potentially negative effects on patients, especially our vulnerable seniors. Policies that have the potential to create access issues for beneficiaries, further provider consolidation, and reduce provider participation in Medicare can drastically deteriorate quality of care our seniors rely on. This would be a step backwards in our unified effort to move to higher quality, more value-based care for our nation's seniors. We ask that you cease all current and future planned mandatory initiatives under the CMMI.

Until recently, the tests and models developed by CMMI were implemented, as intended, on a voluntary, limited-scale basis where no state, healthcare provider, or health insurer had any obligation to participate. However, on November 24<sup>th</sup>, 2015, the Centers for Medicare and Medicaid Services (CMS) published a final rule requiring at least 800 hospitals in 67 geographical areas selected by CMS to participate in a new bundled payment model for hip and knee replacements, the Comprehensive Care Joint Replacement (CJR) Model.<sup>3</sup> Furthermore, on March 8<sup>th</sup>, 2016, CMS released a proposed rule that requires thousands of providers across the country to comply with a new drug payment model under Part B of Medicare.<sup>4,5</sup> The proposed Part B Drug Payment Model is a clear example of the CMMI's overstep of authority, given the mandatory participation required of thousands of providers and millions of patients with serious conditions and rare diseases on a

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<sup>1</sup> Social Security Act Sec. 1115A(a).

<sup>2</sup> CMS bases its authority for the Part B Proposal on Section 1115A, which can be viewed as an unconstitutional delegation of legislative power. Article I, Section 1 of the Constitution prohibits Congress from delegating its legislative powers to other bodies, including executive agencies like CMS. See *Whitman v. Am. Trucking Assn's*, 531 U.S. 457, 472 (2001).

<sup>3</sup> 80 Federal Register 73274, November 24, 2015.

<sup>4</sup> 81 Federal Register 13230, March 11, 2016.

<sup>5</sup> The Demonstration Program would change reimbursement practices for 75 percent of the country.

near-nationwide scale. Most recently, on July 25<sup>th</sup>, 2016, CMS announced the Cardiac Bundled Payment Model (Cardiac Models) that forces one quarter of all metropolitan areas across the nation into bundled payments for certain severe cardiac conditions and expands the controversial CJR Model to include more hip services.<sup>6</sup> In contravention of the statute, these CMMI models were developed absent input from impacted stakeholders and fail to include safeguards to protect the delicate balance of quality, cost, and access to care for beneficiaries. These mandatory models overhaul major payment systems, commandeer clinical decision-making, and dramatically alter the delivery of care.

By focusing solely on cost-savings without adequate regard to the detrimental effects that the CJR Model, Part B Drug Payment Model, and Cardiac Models may potentially have, CMS at best has heeded only part of its statutory duty—“reduc[ing] program expenditures”—at the expense of its other duties—“preserving or enhancing the quality of care.”<sup>7</sup> However, a 2015 blog post by the Congressional Budget Office would suggest that CMMI’s demonstrations do not in fact reduce costs, stating that they have “not yet yielded noticeable savings.”<sup>8,9</sup> In addition to failing to cut costs, mandating participation in large scale demonstrations could have the opposite effect of “preserving or enhancing the quality of care.”<sup>10</sup> We are aware that some models tested under demonstration programs fail to produce quality improvements and anticipated cost savings. This is why the statute authorized the Secretary to “test innovative payment and service delivery models”<sup>11</sup>—not *mandate* them for all providers in designated geographical areas. CMMI’s mandatory models “experiment” with thousands of patient lives without prior testing on a smaller scale or even a basic indication that they will actually achieve improved quality or, at the very least, maintain present quality.

CMMI has failed to meet its statutory requirements for implementing models, including starting with a limited, “Phase I” test, engaging stakeholders in model development, and describing the “defined population” and “deficits in care”<sup>12</sup> the model seeks to address. As a result, Medicare providers and their patients are blindly being forced into high-risk government-dictated reforms with unknown impacts. Any true medical experiment requires patient consent. However, patients residing in an affected geographical area will have no choice about their participation.

As elected Representatives of our constituents and patients who will be directly impacted by these CMMI models or “experiments,” we are limited in our rightful ability to act on behalf of our constituencies to alter, delay or upend these mandatory demonstration programs. CMS’ Part B proposal, for example, would rewrite Medicare Part B payment law in 75 percent of the country without going through the Constitutional procedures where legislation is debated and approved in

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<sup>6</sup>See proposal on July 25, 2016 at <https://innovation.cms.gov/Files/x/advancing-care-coordination-nprm.pdf>

<sup>7</sup> 42 U.S.C. § 1315a(a).

<sup>8</sup> *Estimating the Budgetary Effects of Legislation Involving the Center for Medicare and Medicaid Innovation*, Congressional Budget Office

<sup>9</sup> CBO reiterated the contents of the blogpost in testimony before the House Budget Committee on September 7<sup>th</sup>, 2016. (Mark P. Hadley, *CBO’s Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation*, testimony before the Committee on the Budget, U.S. House of Representatives, 7 September 2016)

<sup>10</sup> As Justice Scalia cautioned, “*Chevron* allows agencies to choose among competing reasonable interpretations of a statute; it does not license interpretive gerrymanders under which an agency keeps parts of statutory context it likes while throwing away parts it does not.” *Michigan v. EPA*, 576 U.S. \_\_\_ (2015), slip op. 9 (citing *Chevron v. NRDC*, 467 U.S. 837 (1984)).

<sup>11</sup> 42 U.S.C. § 1315a(a)(1) (emphasis added).

<sup>12</sup> Social Security Act Sec. 1115A(b)(2)(A).

both chambers of Congress, and subsequently signed by the President. These most basic tenets of our government, intended by our Founding Fathers to preserve and maintain balance of power, have clearly been neglected. CMMI interprets their authority to “test” innovative models on a limited basis as a means to substantially alter both the delivery and reimbursement of care without any input or approval from Congress and the constituents we represent.

Accordingly, we insist CMMI stop experimenting with Americans’ health, and cease all current and future planned mandatory initiatives within the CMMI. Additionally, we ask that you commit to ensuring future CMMI models fully comply with current law, including: limiting the size and scope of CMMI demonstrations so they represent true tests rather than wholesale changes to statute; seeking Congressional approval if expansion of test models require changes to the underlying statute; and establishing an open, transparent process that supports clear and consistent communication with physicians, patients and other relevant stakeholders in the development of new CMMI models.

We look forward to your response detailing next steps as to how the agency plans to ensure that the CMMI will cease current mandatory initiatives and refrain from pursuing any future initiatives that exceed CMMI’s scope of authority.

Sincerely,



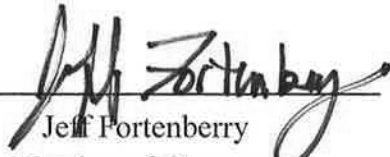
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Member of Congress



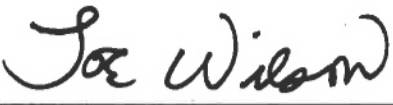
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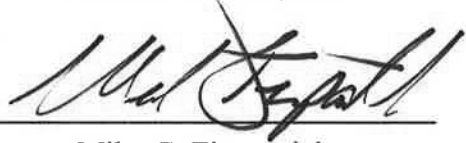
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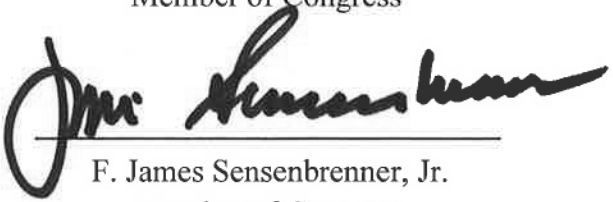
  
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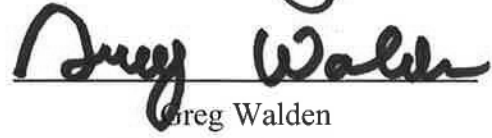
  
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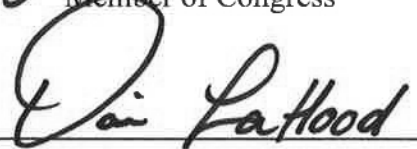
  
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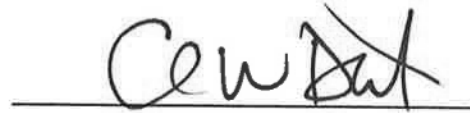
  
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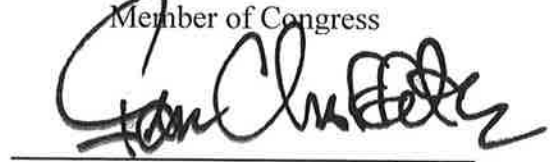
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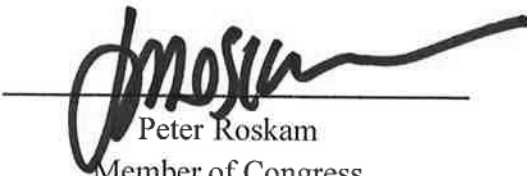
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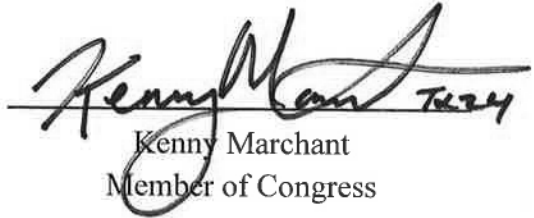
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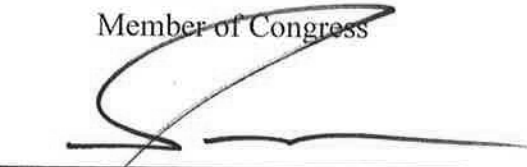
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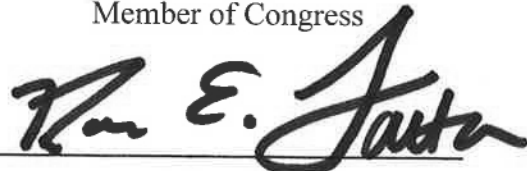
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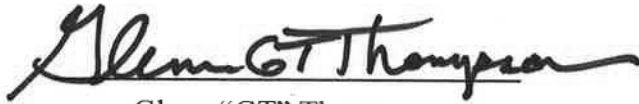
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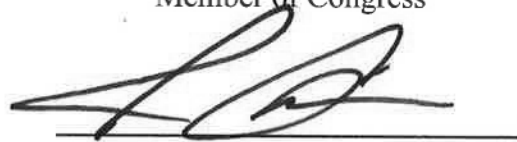
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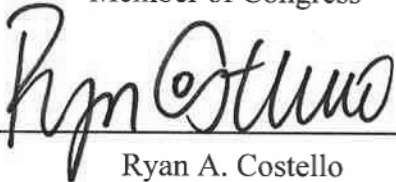
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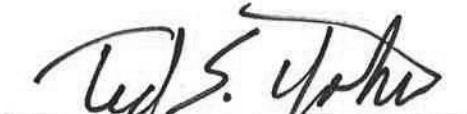
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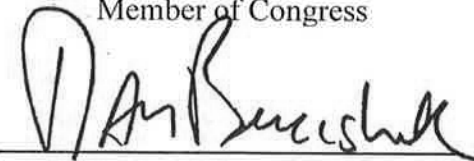
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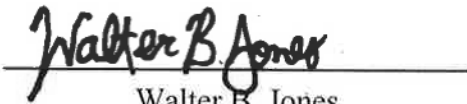
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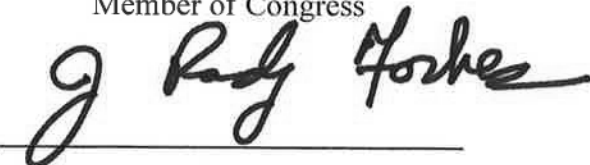
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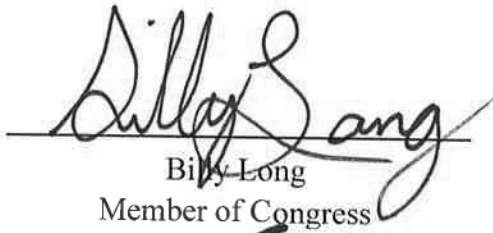
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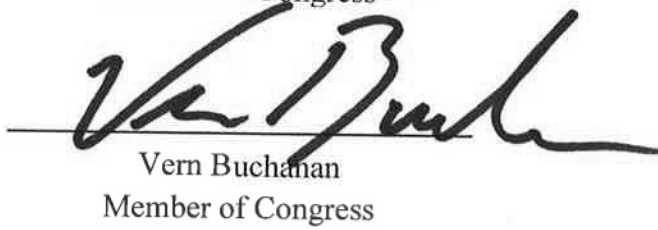
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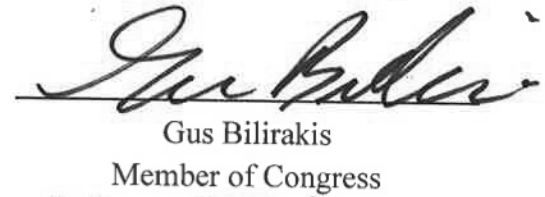


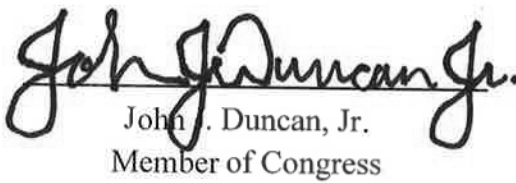
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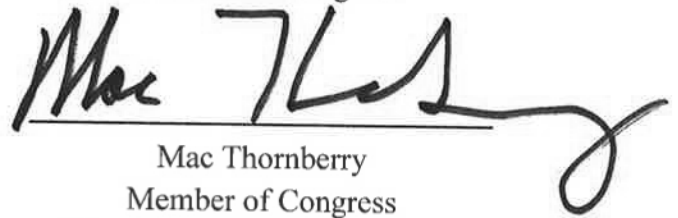
  
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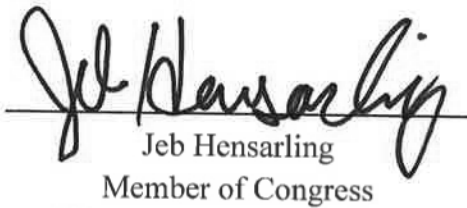
  
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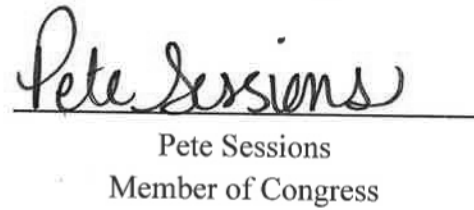
  
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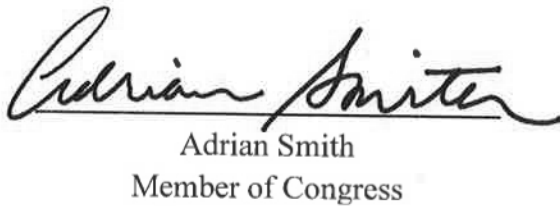
  
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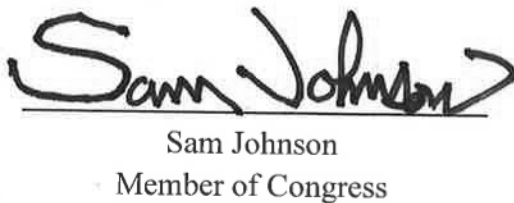
  
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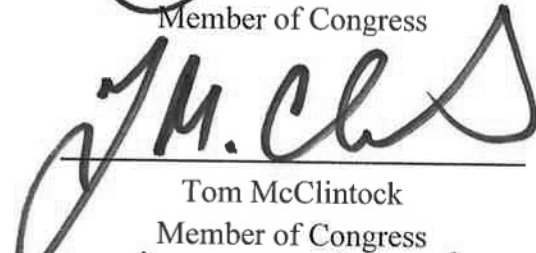
  
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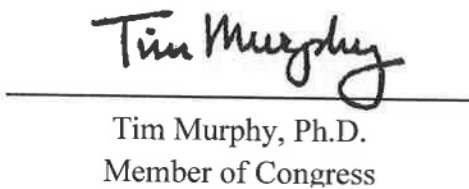
  
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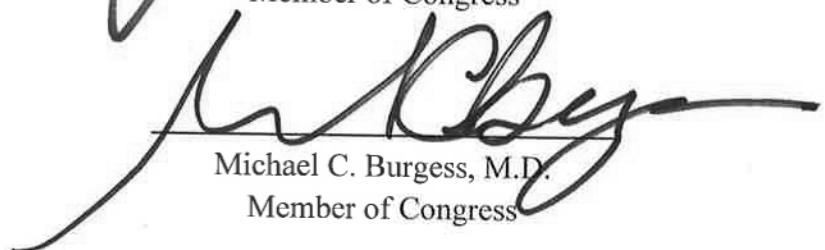
  
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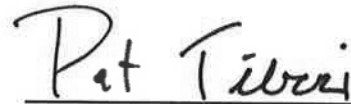
  
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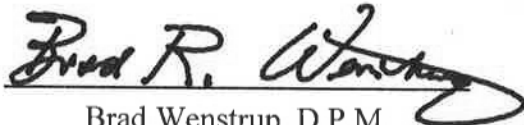
  
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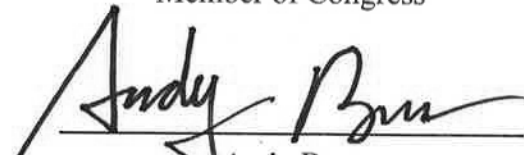
  
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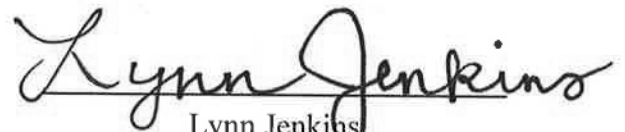
  
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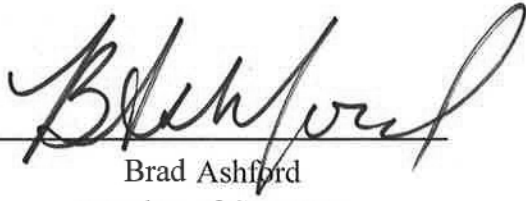
  
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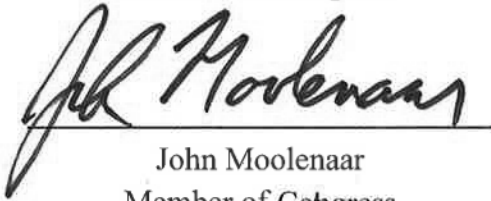
  
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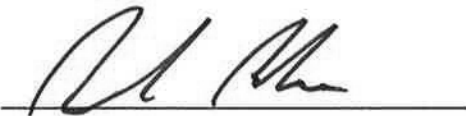
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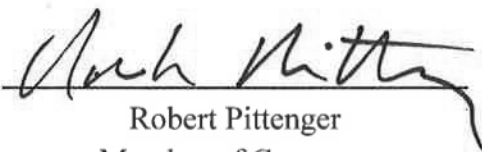
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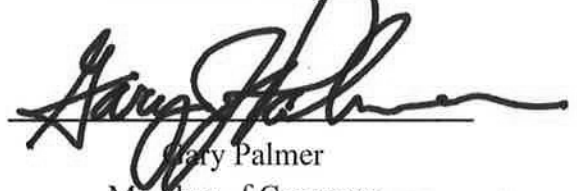
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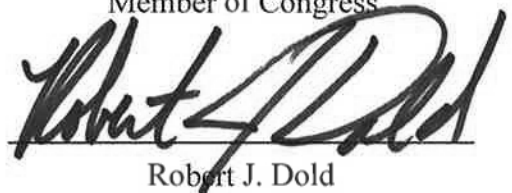
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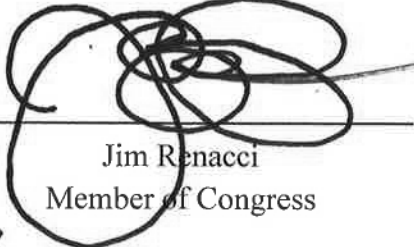
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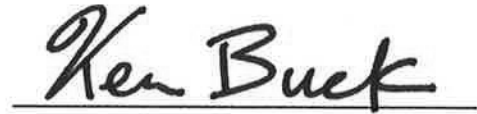
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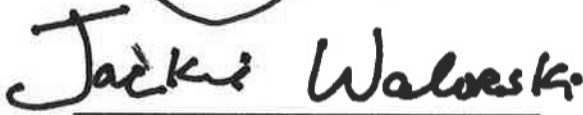
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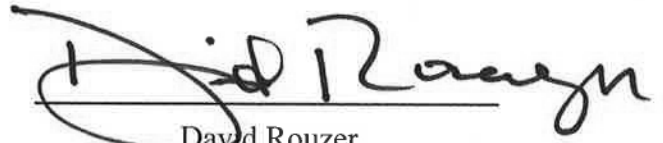
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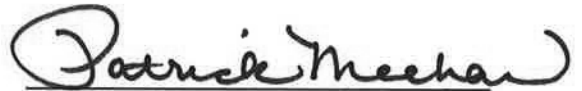
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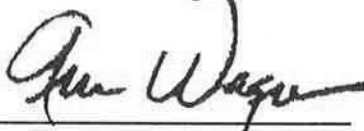
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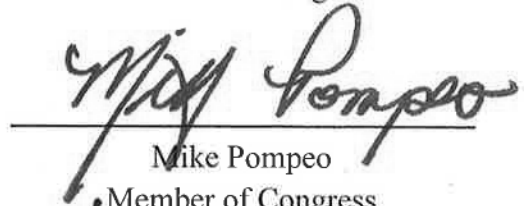
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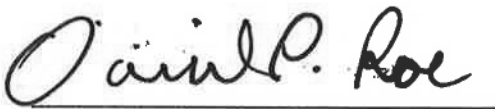
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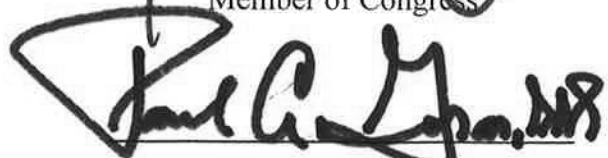
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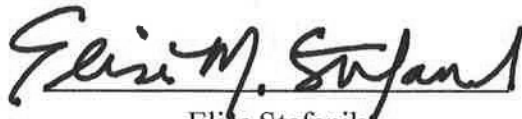
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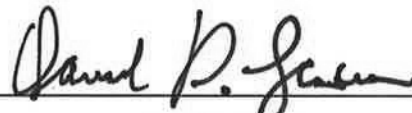
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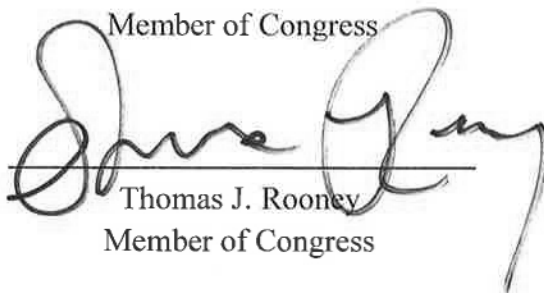
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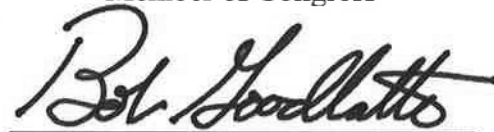
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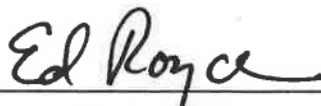
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Member of Congress



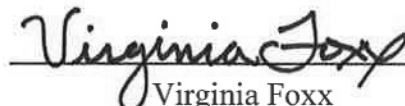
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Member of Congress



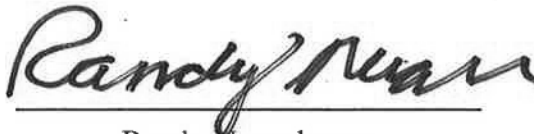
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Member of Congress



Edward R. Royce  
Member of Congress



Virginia Foxx  
Member of Congress



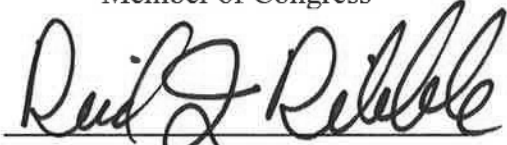
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Carlos Curbelo  
Member of Congress



Mike Bost  
Member of Congress



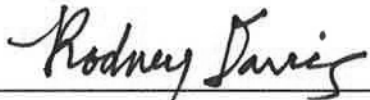
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Member of Congress




Jody Hice  
Member of Congress



Dave Trott  
Member of Congress



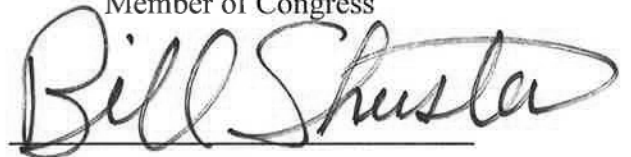
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Member of Congress



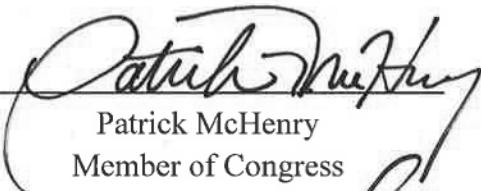
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Member of Congress



Scott Garrett  
Member of Congress



Bill Shuster  
Member of Congress



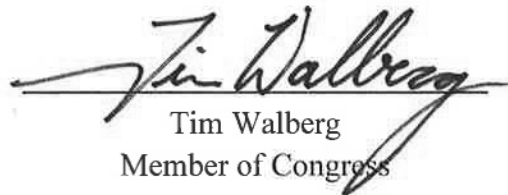
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Member of Congress



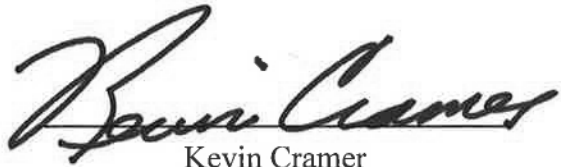
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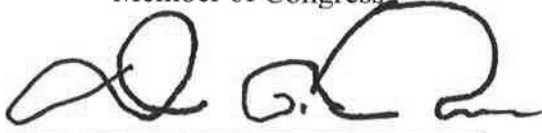
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Member of Congress



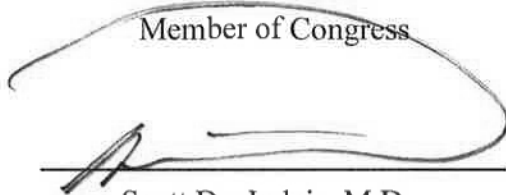
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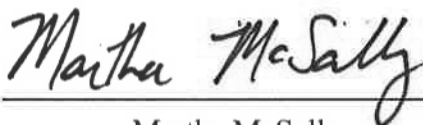
Kevin Cramer  
Member of Congress



Dennis A. Ross  
Member of Congress



Scott DesJarlais, M.D.  
Member of Congress



Martha McSally  
Member of Congress



Jason Smith  
Member of Congress



John Katko  
Member of Congress



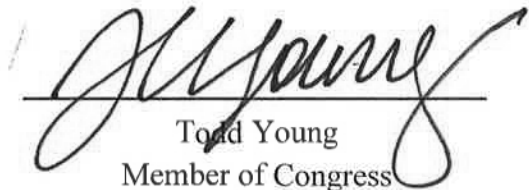
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Member of Congress



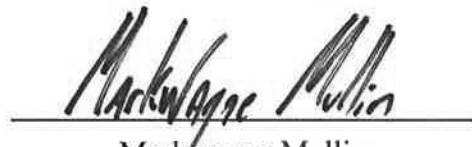
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Member of Congress



Tom Marino  
Member of Congress



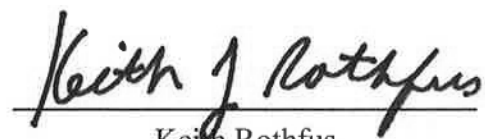
Todd Young  
Member of Congress



Markwayne Mullin  
Member of Congress



Steve Womack  
Member of Congress



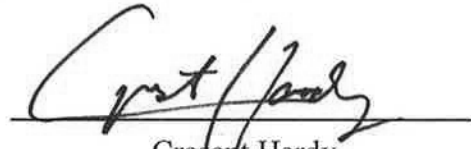
Keith Rothfus  
Member of Congress



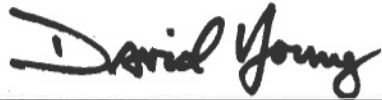
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Member of Congress



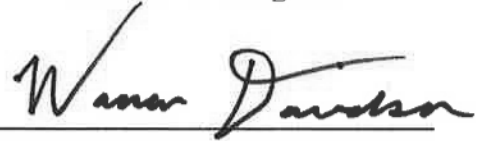
Mike Bishop  
Member of Congress



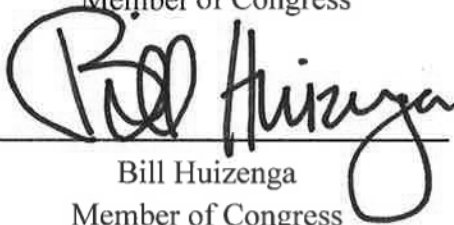
Crest Hardy  
Member of Congress



David Young  
Member of Congress



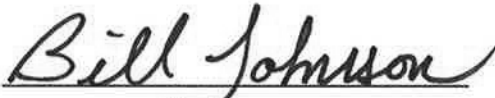
Warren Davidson  
Member of Congress



Bill Huizenga  
Member of Congress



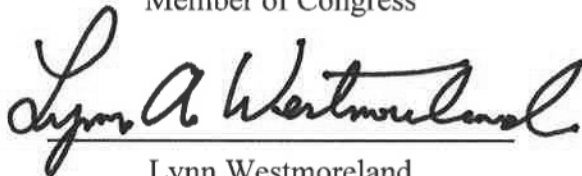
Chris Gibson  
Member of Congress



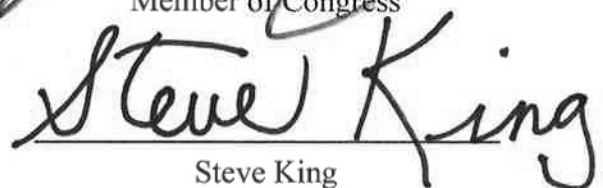
Bill Johnson  
Member of Congress



John Fleming, M.D.  
Member of Congress



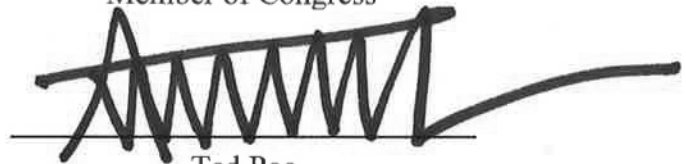
Lynn Westmoreland  
Member of Congress



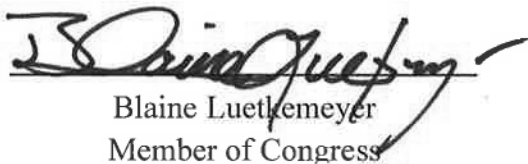
Steve King  
Member of Congress



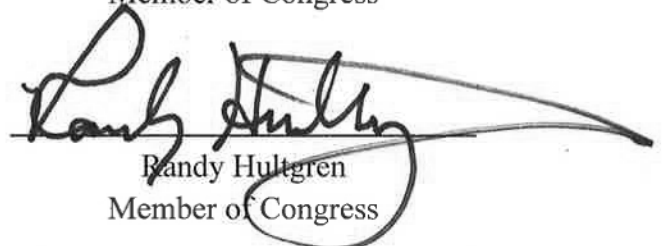
Darrell Issa  
Member of Congress



Ted Poe  
Member of Congress



Blaine Luetkemeyer  
Member of Congress




Randy Hultgren  
Member of Congress




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Jeff Duncan  
Member of Congress




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Bill Posey  
Member of Congress



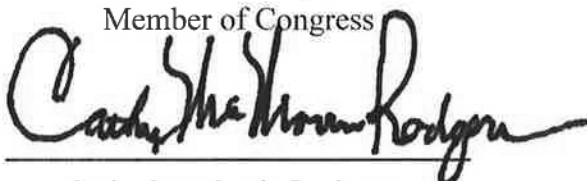
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Rob Bishop  
Member of Congress



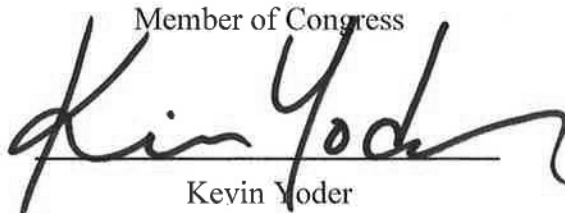
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Michael T. McCaul  
Member of Congress



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Cathy McMorris Rodgers  
Member of Congress



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Kevin Yoder  
Member of Congress




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Mia Love  
Member of Congress



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Barry Loudermilk  
Member of Congress



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Thomas Massie  
Member of Congress




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Dave Brat  
Member of Congress



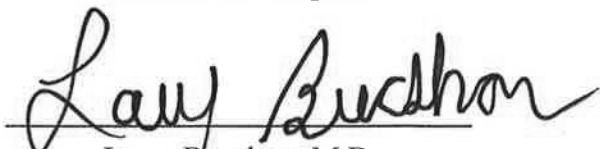
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David B. McKinley  
Member of Congress



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Tom Emmer  
Member of Congress



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Larry Bucshon, M.D.  
Member of Congress



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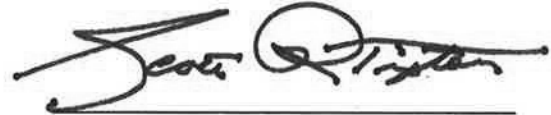
Paul Cook  
Member of Congress





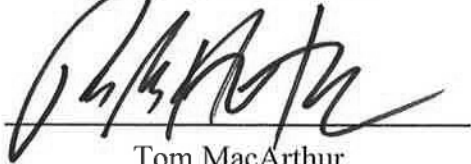
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Ryan Zinke  
Member of Congress




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Scott Tipton  
Member of Congress




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Tom MacArthur  
Member of Congress



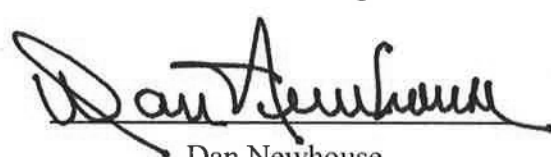
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Alex Mooney  
Member of Congress



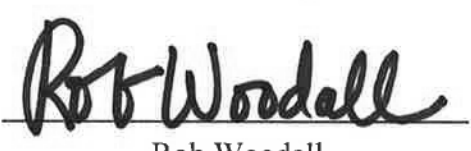
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Doug Collins  
Member of Congress



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Dan Newhouse  
Member of Congress



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Rob Woodall  
Member of Congress



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Dave Reichert  
Member of Congress

**Congress of the United States**  
**Washington, DC 20515**

October 6, 2016

The Hon. Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

The Hon. Shaun Donovan  
Director  
Office of Management and Budget  
725 17<sup>th</sup> Street, NW  
Washington, DC 20503

Dear Acting Administrator Slavitt and Director Donovan:

On April 27<sup>th</sup>, CMS released a proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. By repealing the Sustainable Growth Rate Formula, MACRA has the potential to transform the healthcare landscape and the delivery of care. However, if CMS implements the rule in a manner which is inconsistent with Congressional intent, MACRA has the potential to overcomplicate an already burdensome and complex quality reporting system and take more time away from patient care.<sup>1</sup>

According to a *Health Affairs* study published in March of 2016, physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion each year on quality measure reporting programs. Furthermore, the majority of time spent on quality reporting consists of “entering information into the medical record only for the purpose of reporting quality measures from external entities,” and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized that these programs may actually detract from quality care by driving providers’ time away from patients, and, as a result, replaced them with what is supposed to be a streamlined quality program, known as the Merit-based Incentive Payment System (MIPS).

Under MACRA, providers will use either MIPS or an advanced alternative payment model (APM). In an impact analysis within its proposed MACRA implementation rule, CMS projects that as few as 6% of physicians may participate in qualified APMs. While we believe there are ways to expand the APM option to more physicians, it is clear that the vast majority of physicians will be reporting under MIPS in 2017. Given the immediate focus on MIPS, we are particularly concerned about the complexity of MIPS, the timing of the performance period, and the significant impact of the MIPS program on small and rural practices, among other issues.

We urge you to carefully address a number of multi-layered, high-level concerns that will likely require multi-faceted solutions. Thus, we encourage the agency to take note of the technical issues being presented in the comment letters of the various providers, specialty physicians and medical industry stakeholders.

MACRA brings significant changes to physician workflows, yet most physicians remain entirely

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<sup>1</sup> According to a survey released in July of 2016 by Deloitte, 74% of physicians already find quality reporting to be burdensome.

unaware of MACRA or its implications. Deloitte recently surveyed 600 primary care and specialty physicians regarding MACRA. Of those surveyed, 50% of physicians reported that they have never heard of MACRA, and an additional 32% said that they have heard of it but are unfamiliar with its requirements. Thus, 82% of physicians are unaware of how their reimbursement will be impacted by this new law. Following publication of the final rule and ahead of the start date, the agency must devote significant resources to educate practices about MACRA.

### MIPS is Too Complex

As proposed, even the smallest physician group practices (10 or fewer eligible professionals) would need to expend finite resources on measuring and monitoring their performance on at least 22 measures, including a minimum of eight measures in the quality category, at least two measures in resource use, at least 11 measures in ACI, and at least one measure in the clinical practice improvement activity (CPIA) category.<sup>2</sup> In order to be successful, MIPS must engage clinicians with a reporting system that is not overly burdensome, a scoring system that is simple and transparent, attainable thresholds, and a short enough quality/payment feedback loop to allow physicians to learn and make necessary changes to avoid further penalty.

More detailed feedback reports are needed to assist physicians in understanding their performance rating, including the specific cause for a penalty assessment, the reporting rate for each measure, the calculation methodology and any errors in received data. A transparent process with detailed reports will aid providers to more quickly rectify inaccuracies in their data, and enhance their ability to submit timely appeals before payment reductions are applied and performance ratings are made public. In the past, eligible professionals were left to decipher this rationale on their own, taking valuable time and resources away from patient care.

Within the same vein, an appeals process that is transparent and not administratively burdensome should be readily available to physicians throughout MIPS. An appeals process should have a reasonable time frame for providers to participate, especially given that MIPS will be new to all providers. An appeals process should also promptly address provider concerns with explicit timetables for review.

### Start and Length of Performance Reporting Are Unrealistic

The proposed rule requires MIPS performance measurement to start on January 1, 2017, with the first MIPS payment adjustments being made in January 2019. Physicians and the organizations that represent them have expressed the widely-shared view that the timeline is unrealistic, prompting a recent announcement that CMS intends to give physicians considerable flexibility on when and how they meet MIPS participation requirements in 2017. We share the timeline concerns expressed by our physician colleagues and are encouraged that CMS appears to be taking a step in the right direction. We await further details to determine the extent to which this proposal and other provisions in the final rule alleviate potential problems raised by a 2017 start date. Specifically, we want to be sure that physicians have time to prepare with sufficient notice of program requirements in the final rule and a final list of qualified Advanced APMs.

We also ask CMS to adopt a 90-day reporting period, rather than the year-long period called for in the proposed rule, for the Advancing Care Information (ACI) category of MIPS to enable more small practices to succeed. Especially in the initial years of MIPS, a shorter reporting period is necessary

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<sup>2</sup> Larger practices would have two additional CPIA measures and one additional quality measure.

for all providers, but particularly smaller practices who have fewer resources to keep up with the changing regulatory environment. A shorter reporting period would ensure that more providers are able to successfully make the transition to MIPS, upgrade their EHR technology and meet the new Stage 3 measures by 2018.<sup>3</sup>

#### The Impact of the MIPS Program on Small and Rural Practices will Continue to Drive Consolidation

According to the aforementioned Deloitte study, 58% of physicians say MIPS would encourage them to be part of a larger organization to reduce individual increased financial risk and have access to supporting resources and capabilities. In fact, 80% of surveyed physicians believe MACRA will drive consolidation.

To help reduce administrative burden for small practices and allow for flexibility in quality reporting, CMS should lower its patient minimum reporting thresholds. CMS proposed that providers using a registry must report quality measures on 90% of their patients from all payers, and 80% of Medicare patients for those reporting by claims. This is a significant jump from what is currently 50% of Medicare patients. Such a high minimum threshold would be impossible for many physicians, particularly those in small practices, to meet. We recommend that CMS maintain the minimum threshold at a maximum of 50% of Medicare patients.

Additionally, the MACRA statute included the concept of virtual groups to help assist small practices; however, CMS proposes not to implement virtual groups until the 2018 performance period. The newly-announced participation flexibility policy in 2017 may make this delay more acceptable. However, we strongly urge CMS to act swiftly on forming these groups as soon as possible to ensure that this option is communicated to physicians early enough to provide them with sufficient time to organize and participate. Without this assistance, we believe small practices face even greater challenges when attempting to adapt to the MIPS program structure.

CMS should also broaden its MIPS exclusion for providers who treat a low volume of Medicare patients. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians from MIPS if their practice has less than \$10,000 in Medicare allowed charges *and* fewer than 100 unique Medicare patients per year. The proposed threshold, however, would help very few physicians and other clinicians. An AMA analysis of the 2014 “Medicare Provider Utilization and Payment Data: Physician and Other Supplier” file found that just 10% of physicians and 16% of all MIPS eligible clinicians would be exempt under the \$10,000/100 beneficiary proposal, and that these clinicians account for less than one percent of total Medicare allowed charges for Physician Fee Schedule services. As one example, by increasing the threshold to \$30,000 in Medicare allowed charges *or* fewer than 100 unique Medicare patients seen by the physician, CMS would provide a better safety net for small providers. This would exclude less than 30% of physicians while still subjecting more than 93% of allowed spending to MIPS. We recommend that the low-volume threshold be raised significantly in the final rule.

#### Resource Measures May Not Provide Accurate and Relevant Assessment of Physician Performance

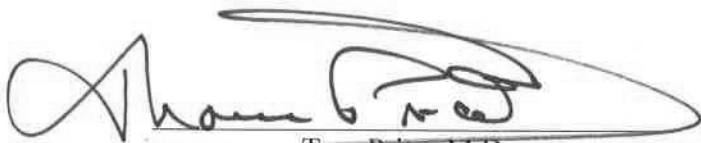
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<sup>3</sup> CMS must minimize any unfair negative impact to small practices. In Table 64 of the proposed rule, CMS estimates that a disproportionate number of solo practitioners and small practices would fail the Merit-Based Incentive Program and would experience financial penalties as a result. CMS should modify its proposals to ensure an equal opportunity for all providers to succeed in the program.

Resource use measures that CMS has used in the value-based modifier were originally developed for use in hospitals and are neither accurate nor relevant for many physicians. Recognizing this, Congress made clear that this category under MIPS should be limited to 10% *or less* of the total MIPS score in the first year and 15% *or less* in 2020. MACRA also called for the development of new episode measures and physician-patient relationship codes that are intended to improve the reliability and relevance of scores in this category. Final versions of the physician-patient relationship codes are not due to take effect until 2018 and many of the episode measures that CMS has developed to date have not been adequately reviewed by physicians or tested for use in physician offices. We believe that CMS should make the resource use category optional for at least one year while the measures and related methodologies are refined.

We strongly urge CMS to make necessary changes in the final rule so that physicians may be provided with the tools necessary to succeed under this new payment regime. We look forward to continuing to work with CMS to ensure effective implementation of this rule.

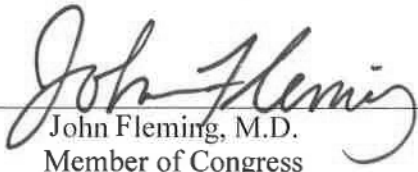
Sincerely,

A handwritten signature in black ink, appearing to read "Tom Price", with a large, sweeping flourish extending from the end of the signature.

Tom Price, M.D.  
Member of Congress

A handwritten signature in black ink, appearing to read "David P. Roe", written in a cursive style.

David P. Roe, M.D.  
Member of Congress



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John Fleming, M.D.  
Member of Congress



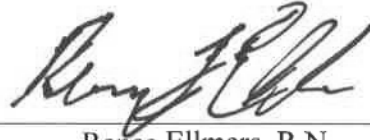
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Andy Harris, M.D.  
Member of Congress



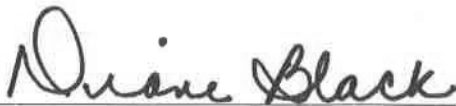
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Brad Wenstrup, D.P.M.  
Member of Congress



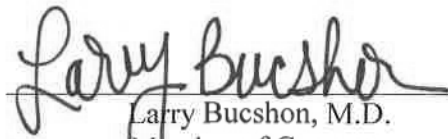
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Renee Ellmers, R.N.  
Member of Congress



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Diane Black, R.N.  
Member of Congress



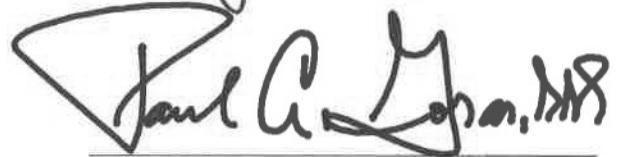
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Larry Bucshon, M.D.  
Member of Congress



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Dan Benishek, M.D.  
Member of Congress



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



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Earl L. "Buddy" Carter  
Member of Congress



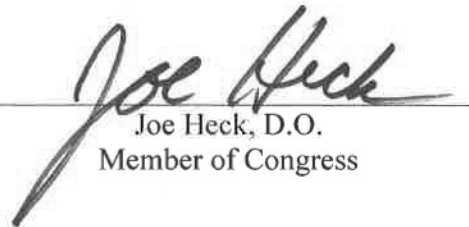
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Ralph Abraham, M.D.  
Member of Congress



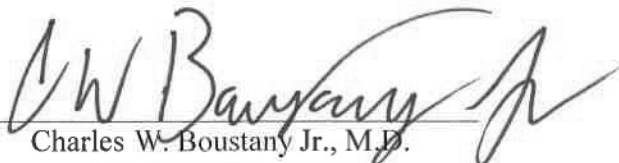
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Brian Babin, D.D.S.  
Member of Congress



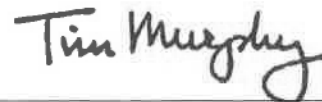
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Joe Heck, D.O.  
Member of Congress




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



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Tim Murphy, PhD  
Member of Congress

A stylized, cursive handwritten signature in black ink, consisting of a large, sweeping loop at the top and a smaller loop below it.

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Scott DesJarlais, M.D.  
Member of Congress

A cursive handwritten signature in black ink, with the first name 'Mike' and last name 'Simpson' clearly legible.

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Mike Simpson, D.M.D.  
Member of Congress



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Jason Chaffetz  
House of Representatives  
Washington, DC 20515

Dear Representative Chaffetz:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

First, under the statute and conforming regulations, CMS is required to ensure that communications provided to Medicare beneficiaries are accurate and not confusing or misleading. Second, CMS is required to ensure that plans do not misuse beneficiary information for purposes inconsistent with restrictions they have agreed to in their contract on the use of such information. Third, CMS is required to ensure that Federal funds paid to contracting entities, including MA plans, are not used for impermissible purposes such as lobbying.

With regard to Humana, the communications in question had the potential to be confusing and/or misleading to beneficiaries. The specific mailing of concern included the following statement on the envelope, "Important information about your Medicare Advantage plan--open today!" The statement on the envelope purported to have current plan benefit information, it could be misleading to a beneficiary since the information inside the envelope instead discussed pending health reform legislation. Given that MA and Part D prescription drug plans were soon to begin mailing annual required notices to beneficiaries about specific changes to plan benefits or plan structures for the upcoming year, wholly unrelated to any possible future legislative changes, the timing and content of this messaging was particularly concerning to the Agency. Under section 1851(h)(1) of the Social Security Act (incorporated for Part D under section 1860D-1(b)(vi) plans are required to submit all materials defined as marketing to CMS for review and approval prior to sending them to their Medicare enrollees. The regulations define "marketing materials" to include "any information targeted to Medicare beneficiaries" that, among other things, provides information on plan benefits (42 CFR 422.2260; 423.2260). We are concerned that the particular mailing in question violated these regulations because it purported to provide MA enrollees with "information" about their "Medicare Advantage plan" that suggested that the mailing contained "official" information from the Medicare program about the enrollee's Medicare plan, when this was not the case.

The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data



obtained by virtue of their contracts with CMS only for purposes of administering their plans. CMS is investigating whether plans inappropriately used beneficiary data subject to this limitation in their health care reform outreach efforts.

Finally, we are concerned that Federal funds not be used improperly for activities that are prohibited under the Department of Health and Human Services' (HHS) appropriations acts. HHS's appropriations acts very specifically provide that no appropriated funds may be used to pay the "salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature. See *Division F, Title V, Section 503(b)*, Departments of Labor, HHS, and Education Appropriations Act, 2009, as enacted by Section 5, Omnibus Appropriations Act, 2009, Pub. L. 111-8, 123 Stat. 524,802 (March 11, 2009). Because administrative costs incurred by MA and Part D prescription drug plans are included in their "bids," and these bids form the basis for Medicare payments, CMS needs to ensure that no Federal funds were used for the lobbying activities in question. I should note that under recent audits, it appears that in some cases lobbying costs may have been included as administrative costs in Medicare health and drug plan bids. CMS is therefore committed to ensuring that plans have not done so in this case, and that other contracted organizations contemplating lobbying activities also do not pay for these activities with Federal funds.

To be clear, HHS believes that contracted organizations that sponsor MA and prescription drug plans may communicate their views on pending legislation with no interference from CMS or others in the Department, assuming compliance with the provisions noted above. Indeed, such communication may be outside of HHS review if done by the corporate sponsors of these plans with no interaction (e.g., use of funds or protected beneficiary information) with Medicare. You also ask about mailings by the Association for the Advancement of Retired Persons (AARP), and specifically whether any enforcement actions were initiated by CMS regarding AARP mailings. The AARP is not a Medicare contractor and maintains its own membership records. The Medicare health and drug plans advertised by AARP are sponsored by United Health Group under contract with CMS, and therefore mailings by United Health Group are included in our overall investigation.

I appreciate your interest in our actions since we share a responsibility to Medicare beneficiaries and taxpayers to ensure fair and appropriate communication and information. To ensure that any compliance and enforcement actions are appropriately and consistently applied, CMS will continue its review to determine whether Medicare contractors that sponsor health and drug plans may have violated marketing guidelines and other provisions noted above. In addition, CMS prepared a ready reference for Medicare health and drug plan sponsors on outreach related activities providing summary guidance that compiles all the relevant statutes and guiding regulations in this area.

Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*

Washington, DC 20201

The Honorable Blaine Luetkemeyer  
House of Representatives  
Washington, DC 20515

Dear Representative Luetkemeyer:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

First, under the statute and conforming regulations, CMS is required to ensure that communications provided to Medicare beneficiaries are accurate and not confusing or misleading. Second, CMS is required to ensure that plans do not misuse beneficiary information for purposes inconsistent with restrictions they have agreed to in their contract on the use of such information. Third, CMS is required to ensure that Federal funds paid to contracting entities, including MA plans, are not used for impermissible purposes such as lobbying.

With regard to Humana, the communications in question had the potential to be confusing and/or misleading to beneficiaries. The specific mailing of concern included the following statement on the envelope, "Important information about your Medicare Advantage plan--open today!" The statement on the envelope purported to have current plan benefit information, it could be misleading to a beneficiary since the information inside the envelope instead discussed pending health reform legislation. Given that MA and Part D prescription drug plans were soon to begin mailing annual required notices to beneficiaries about specific changes to plan benefits or plan structures for the upcoming year, wholly unrelated to any possible future legislative changes, the timing and content of this messaging was particularly concerning to the Agency. Under section 1851(h)(1) of the Social Security Act (incorporated for Part D under section 1860D-1(b)(vi) plans are required to submit all materials defined as marketing to CMS for review and approval prior to sending them to their Medicare enrollees. The regulations define "marketing materials" to include "any information targeted to Medicare beneficiaries" that, among other things, provides information on plan benefits (42 CFR 422.2260; 423.2260). We are concerned that the particular mailing in question violated these regulations because it purported to provide MA enrollees with "information" about their "Medicare Advantage plan" that suggested that the mailing contained "official" information from the Medicare program about the enrollee's Medicare plan, when this was not the case.

The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data

obtained by virtue of their contracts with CMS only for purposes of administering their plans. CMS is investigating whether plans inappropriately used beneficiary data subject to this limitation in their health care reform outreach efforts.

Finally, we are concerned that Federal funds not be used improperly for activities that are prohibited under the Department of Health and Human Services' (HHS) appropriations acts. HHS's appropriations acts very specifically provide that no appropriated funds may be used to pay the "salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature. See *Division F, Title V, Section 503(b)*, Departments of Labor, HHS, and Education Appropriations Act, 2009, as enacted by Section 5, Omnibus Appropriations Act, 2009, Pub. L. 111-8, 123 Stat. 524,802 (March 11, 2009). Because administrative costs incurred by MA and Part D prescription drug plans are included in their "bids," and these bids form the basis for Medicare payments, CMS needs to ensure that no Federal funds were used for the lobbying activities in question. I should note that under recent audits, it appears that in some cases lobbying costs may have been included as administrative costs in Medicare health and drug plan bids. CMS is therefore committed to ensuring that plans have not done so in this case, and that other contracted organizations contemplating lobbying activities also do not pay for these activities with Federal funds.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Dan Lungren  
House of Representatives  
Washington, DC 20515

Dear Representative Lungren:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable John Sminkus  
House of Representatives  
Washington, DC 20515

Dear Representative Sminkus:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Joe Pitts  
House of Representatives  
Washington, DC 20515

Dear Representative Pitts:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Roscoe Bartlett  
House of Representatives  
Washington, DC 20515

Dear Representative Bartlett:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Aaron Shock  
House of Representatives  
Washington, DC 20515

Dear Representative Shock:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Marsha Blackburn  
House of Representatives  
Washington, DC 20515

Dear Representative Blackburn:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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With regard to Humana, the communications in question had the potential to be confusing and/or misleading to beneficiaries. The specific mailing of concern included the following statement on the envelope, "Important information about your Medicare Advantage plan--open today!" The statement on the envelope purported to have current plan benefit information, it could be misleading to a beneficiary since the information inside the envelope instead discussed pending health reform legislation. Given that MA and Part D prescription drug plans were soon to begin mailing annual required notices to beneficiaries about specific changes to plan benefits or plan structures for the upcoming year, wholly unrelated to any possible future legislative changes, the timing and content of this messaging was particularly concerning to the Agency. Under section 1851(h)(1) of the Social Security Act (incorporated for Part D under section 1860D-1(b)(vi) plans are required to submit all materials defined as marketing to CMS for review and approval prior to sending them to their Medicare enrollees. The regulations define "marketing materials" to include "any information targeted to Medicare beneficiaries" that, among other things, provides information on plan benefits (42 CFR 422.2260; 423.2260). We are concerned that the particular mailing in question violated these regulations because it purported to provide MA enrollees with "information" about their "Medicare Advantage plan" that suggested that the mailing contained "official" information from the Medicare program about the enrollee's Medicare plan, when this was not the case.

The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data

obtained by virtue of their contracts with CMS only for purposes of administering their plans. CMS is investigating whether plans inappropriately used beneficiary data subject to this limitation in their health care reform outreach efforts.

Finally, we are concerned that Federal funds not be used improperly for activities that are prohibited under the Department of Health and Human Services' (HHS) appropriations acts. HHS's appropriations acts very specifically provide that no appropriated funds may be used to pay the "salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature. See *Division F, Title V, Section 503(b)*, Departments of Labor, HHS, and Education Appropriations Act, 2009, as enacted by Section 5, Omnibus Appropriations Act, 2009, Pub. L. 111-8, 123 Stat. 524,802 (March 11, 2009). Because administrative costs incurred by MA and Part D prescription drug plans are included in their "bids," and these bids form the basis for Medicare payments, CMS needs to ensure that no Federal funds were used for the lobbying activities in question. I should note that under recent audits, it appears that in some cases lobbying costs may have been included as administrative costs in Medicare health and drug plan bids. CMS is therefore committed to ensuring that plans have not done so in this case, and that other contracted organizations contemplating lobbying activities also do not pay for these activities with Federal funds.

To be clear, HHS believes that contracted organizations that sponsor MA and prescription drug plans may communicate their views on pending legislation with no interference from CMS or others in the Department, assuming compliance with the provisions noted above. Indeed, such communication may be outside of HHS review if done by the corporate sponsors of these plans with no interaction (e.g., use of funds or protected beneficiary information) with Medicare. You also ask about mailings by the Association for the Advancement of Retired Persons (AARP), and specifically whether any enforcement actions were initiated by CMS regarding AARP mailings. The AARP is not a Medicare contractor and maintains its own membership records. The Medicare health and drug plans advertised by AARP are sponsored by United Health Group under contract with CMS, and therefore mailings by United Health Group are included in our overall investigation.

I appreciate your interest in our actions since we share a responsibility to Medicare beneficiaries and taxpayers to ensure fair and appropriate communication and information. To ensure that any compliance and enforcement actions are appropriately and consistently applied, CMS will continue its review to determine whether Medicare contractors that sponsor health and drug plans may have violated marketing guidelines and other provisions noted above. In addition, CMS prepared a ready reference for Medicare health and drug plan sponsors on outreach related activities providing summary guidance that compiles all the relevant statutes and guiding regulations in this area.

Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Lynn Jenkins  
House of Representatives  
Washington, DC 20515

Dear Representative Jenkins:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

First, under the statute and conforming regulations, CMS is required to ensure that communications provided to Medicare beneficiaries are accurate and not confusing or misleading. Second, CMS is required to ensure that plans do not misuse beneficiary information for purposes inconsistent with restrictions they have agreed to in their contract on the use of such information. Third, CMS is required to ensure that Federal funds paid to contracting entities, including MA plans, are not used for impermissible purposes such as lobbying.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*

Washington, DC 20201

DEC 16 2009

The Honorable Jo Bonner  
House of Representatives  
Washington, DC 20515

Dear Representative Bonner:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable George Radanovich  
House of Representatives  
Washington, DC 20515

Dear Representative Radanovich:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Paul Broun  
House of Representatives  
Washington, DC 20515

Dear Representative Broun:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Mark Souder  
House of Representatives  
Washington, DC 20515

Dear Representative Souder:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Waller Herger  
House of Representatives  
Washington, DC 20515

Dear Representative Herger:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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I appreciate your interest in our actions since we share a responsibility to Medicare beneficiaries and taxpayers to ensure fair and appropriate communication and information. To ensure that any compliance and enforcement actions are appropriately and consistently applied, CMS will continue its review to determine whether Medicare contractors that sponsor health and drug plans may have violated marketing guidelines and other provisions noted above. In addition, CMS prepared a ready reference for Medicare health and drug plan sponsors on outreach related activities providing summary guidance that compiles all the relevant statutes and guiding regulations in this area.

Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Louie Gohmert  
House of Representatives  
Washington, DC 20515

Dear Representative Gohmert:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

First, under the statute and conforming regulations, CMS is required to ensure that communications provided to Medicare beneficiaries are accurate and not confusing or misleading. Second, CMS is required to ensure that plans do not misuse beneficiary information for purposes inconsistent with restrictions they have agreed to in their contract on the use of such information. Third, CMS is required to ensure that Federal funds paid to contracting entities, including MA plans, are not used for impermissible purposes such as lobbying.

With regard to Humana, the communications in question had the potential to be confusing and/or misleading to beneficiaries. The specific mailing of concern included the following statement on the envelope, "Important information about your Medicare Advantage plan--open today!" The statement on the envelope purported to have current plan benefit information, it could be misleading to a beneficiary since the information inside the envelope instead discussed pending health reform legislation. Given that MA and Part D prescription drug plans were soon to begin mailing annual required notices to beneficiaries about specific changes to plan benefits or plan structures for the upcoming year, wholly unrelated to any possible future legislative changes, the timing and content of this messaging was particularly concerning to the Agency. Under section 1851(h)(1) of the Social Security Act (incorporated for Part D under section 1860D-1(b)(vi)) plans are required to submit all materials defined as marketing to CMS for review and approval prior to sending them to their Medicare enrollees. The regulations define "marketing materials" to include "any information targeted to Medicare beneficiaries" that, among other things, provides information on plan benefits (42 CFR 422.2260; 423.2260). We are concerned that the particular mailing in question violated these regulations because it purported to provide MA enrollees with "information" about their "Medicare Advantage plan" that suggested that the mailing contained "official" information from the Medicare program about the enrollee's Medicare plan, when this was not the case.

The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data

obtained by virtue of their contracts with CMS only for purposes of administering their plans. CMS is investigating whether plans inappropriately used beneficiary data subject to this limitation in their health care reform outreach efforts.

Finally, we are concerned that Federal funds not be used improperly for activities that are prohibited under the Department of Health and Human Services' (HHS) appropriations acts. HHS's appropriations acts very specifically provide that no appropriated funds may be used to pay the "salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature. See *Division F, Title V, Section 503(b)*, Departments of Labor, HHS, and Education Appropriations Act, 2009, as enacted by Section 5, Omnibus Appropriations Act, 2009, Pub. L. 111-8, 123 Stat. 524,802 (March 11, 2009). Because administrative costs incurred by MA and Part D prescription drug plans are included in their "bids," and these bids form the basis for Medicare payments, CMS needs to ensure that no Federal funds were used for the lobbying activities in question. I should note that under recent audits, it appears that in some cases lobbying costs may have been included as administrative costs in Medicare health and drug plan bids. CMS is therefore committed to ensuring that plans have not done so in this case, and that other contracted organizations contemplating lobbying activities also do not pay for these activities with Federal funds.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Mike Conaway  
House of Representatives  
Washington, DC 20515

Dear Representative Conaway:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



*Administrator*  
Washington, DC 20201

DEC 16 2009

The Honorable Todd Akin  
House of Representatives  
Washington, DC 20515

Dear Representative Akin:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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The Agency had a second concern about misuse of beneficiary information given that Part C and Part D plans sign an attestation under which they agree to use Medicare beneficiary data



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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*

Washington, DC 20201

The Honorable Trent Franks  
House of Representatives  
Washington, DC 20515

Dear Representative Franks:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

In particular, you question the motivation underlying the Agency's actions, including the investigation into Humana. This letter responds by summarizing the three overarching concerns that led CMS to take immediate action and also identifies several statutory and regulatory authorities supporting the action.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Jack Kingston  
House of Representatives  
Washington, DC 20515

Dear Representative Kingston:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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Sincerely,



Charlene Frizzera  
Acting Administrator



DEC 16 2009

*Administrator*  
Washington, DC 20201

The Honorable Cathy McMorris Rodger  
House of Representatives  
Washington, DC 20515

Dear Representative McMorris Rodger:

Thank you for your letter regarding steps taken by the Centers for Medicare & Medicaid Services (CMS) to address information disseminated by certain Medicare Advantage (MA) plans. We appreciate the opportunity to respond to this matter.

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Sincerely,



Charlene Frizzera  
Acting Administrator



RECEIVED

OCT 07 2009

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

**Fax Cover Sheet**  
**Congressman Tom Price**  
**6<sup>th</sup> District of Georgia**  
**424 Cannon House Office Building**  
**Washington, DC 20515**  
**Phone: (202) 225-4501**  
**Fax: (202) 225-4656**

**To: Acting Administrator Frizzera**

**From: Emily Henehan Murry**

**Comments: Letter to CMS regarding the recent gag order on Medicare Advantage plans and dealing with AARP**

**Number of Pages including Cover Sheet: 5**



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# Congress of the United States

Washington, DC 20515

September 30, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Acting Administrator Frizzera:

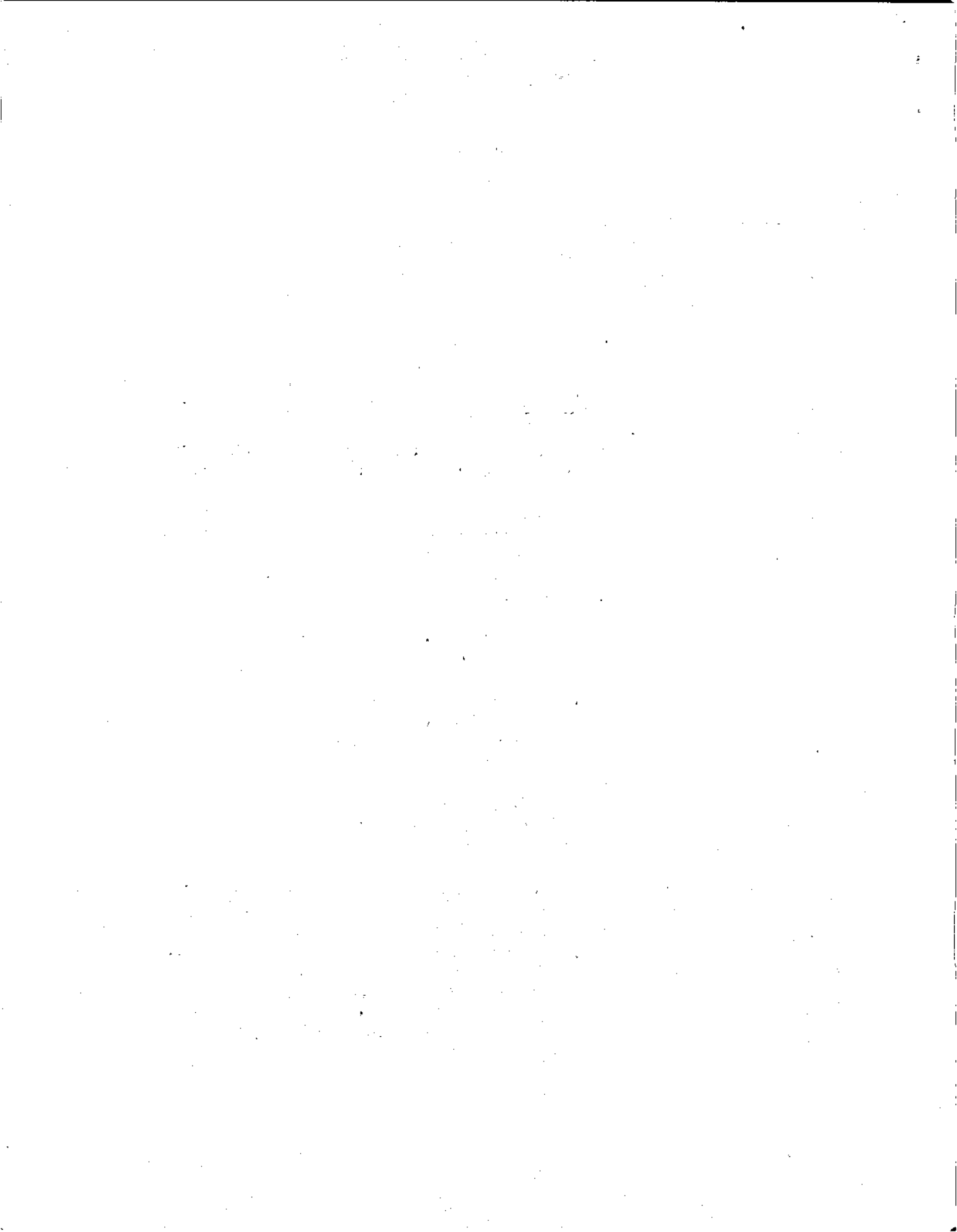
We are writing to express our opposition to the recent gag order the Centers for Medicare and Medicaid Services (CMS) has placed on all Medicare Advantage plans relating to factual information about how pending health reform legislation may negatively affect their beneficiaries' access and coverage. American seniors deserve to know how their coverage would be affected by the plans being promoted by the President and Congress.

CMS's letter to Humana instituting the gag order stated "CMS is concerned that, among other things, this information is misleading and confusing to beneficiaries..." However, the information presented by Humana to beneficiaries is not misleading; in fact CBO affirmed that millions of seniors could lose benefits or have their premium costs go up, thus limiting access. Humana in its communications to beneficiaries wrote:

Leading health reform proposals being considered in Washington, D.C., this summer include billions in Medicare Advantage funding cuts, as well as spending reductions to original Medicare and Medicaid. While these programs need to be made more efficient, if the proposed funding cut levels become law, millions of seniors and disabled individuals could lose many of the important benefits and services that make Medicare Advantage health plans so valuable.

We are concerned that CMS is misusing its regulatory powers to influence the debate, and we believe it is not their proper role to limit freedom of speech by silencing companies who have opposing views to the current administration.

Curiously, the lobbying activities of the AARP, which sponsors Medicare Advantage and Medigap plans, and has been vocally *supportive* of pending health reform legislation, appear to have been overlooked by CMS. AARP stated on its website that it is a "myth" that "health care reform will hurt Medicare," while it is a "fact" that "none of the health care reform proposals being considered by Congress will cut Medicare benefits or increase your out-of-pocket costs." We believe this to be inaccurate; however we trust seniors to be able to determine who is providing them with the most trustworthy information. If CMS were to apply the same standards, taking into account CBO's analysis, AARP's statement would surely qualify as "misleading and confusing".



Therefore, we respectfully request that the CMS gag order be rescinded on any communication related to pending health legislation in Congress. Furthermore, we request that CMS release all communications between the Agency and AARP since the beginning of this calendar year.

We appreciate your attention to this issue and look forward to your prompt response.

Yours truly,

Thomas P. ...  
SA-06

R. ... TX-11

W. ... MO-2

Frank ...

Scott Kingston SA-1

Joe ... PA-16

Wally Herger  
Wally Herger Coa

... WA-05

Sharon ... UT-3

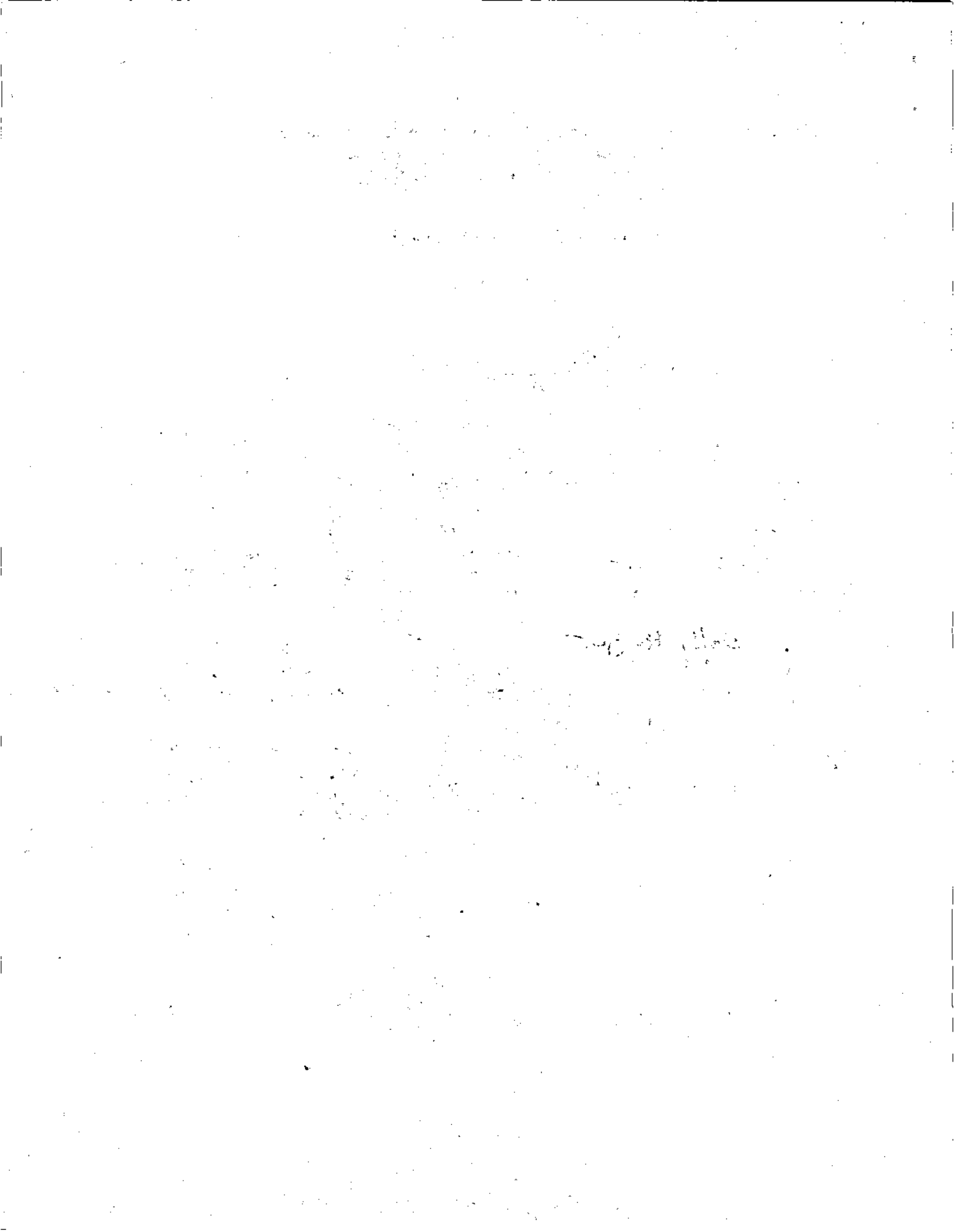
... TX-1

Blaine ... MO-05

David E. ... CA-3

Jeff ... IL-19

... MD-6



Steve Seave

Marsha Bachman

Doug Lamborn CO-05

Jo Wilson

Carl Brown

Michelle Bachmann

Redney Alexander VA-05

Hyatt

St. Inglis

Aym Jenkins

Pete Olson

Ann Schick

Eric

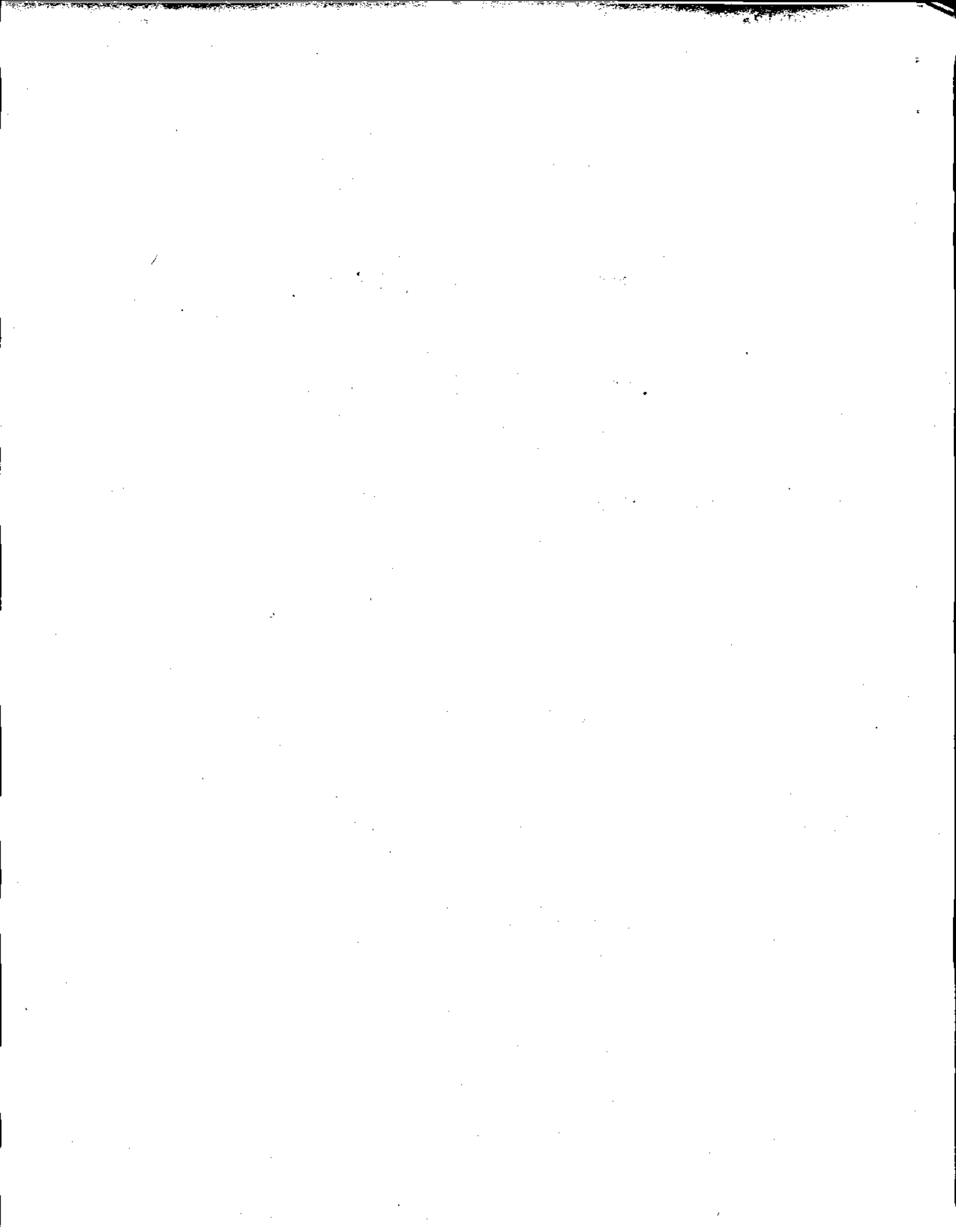
Bob

Bob Goodlatte

Jo Bonner

Mark Linder

Jerry Moran



Brian P. Gilbert      Wampinton

John Fleming      Gary Padanovich

Coryellia M. Shuman      Gumbelir

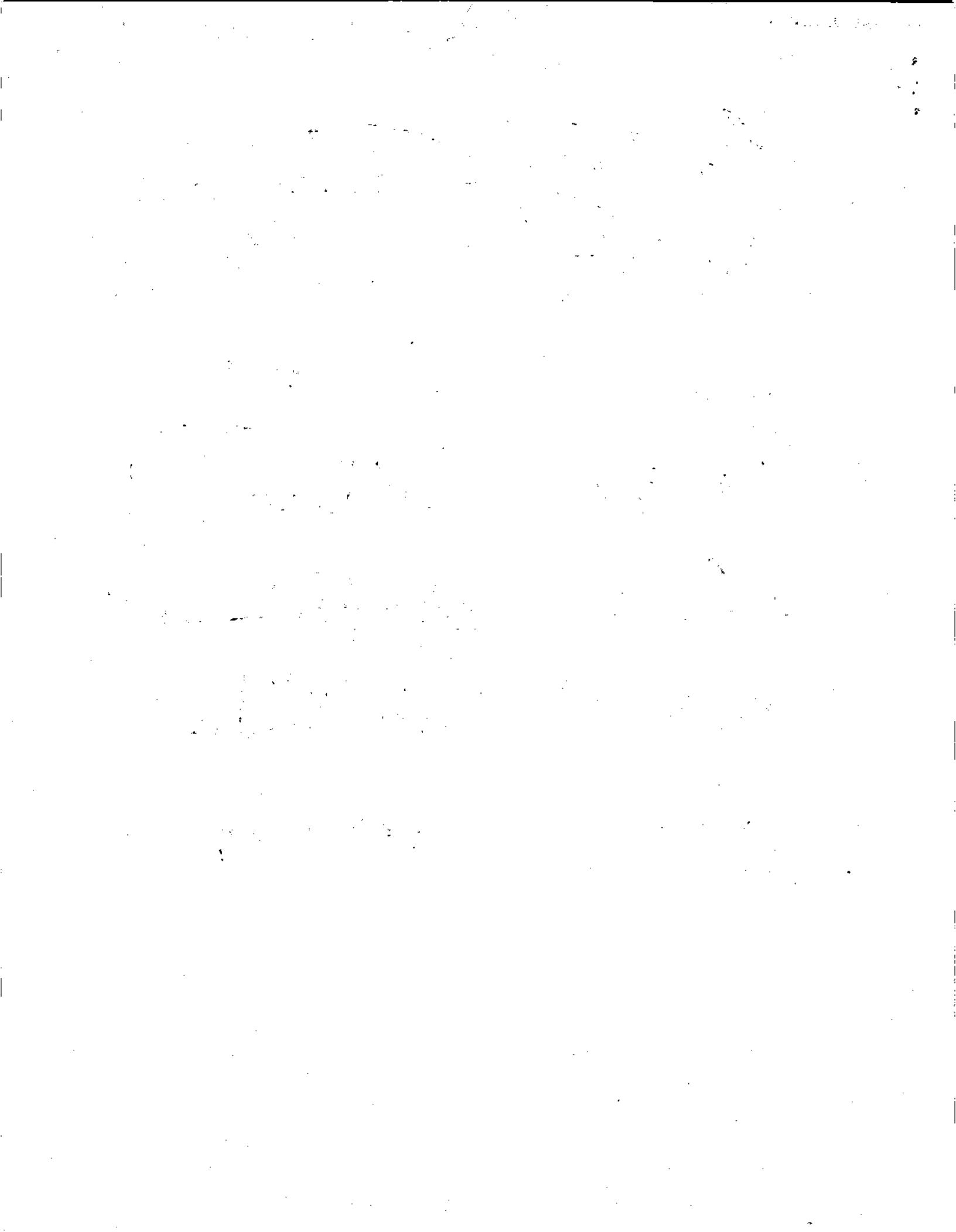
Virginia Fox      Lynette

John Kline      Shihfeng (IN-6)

Robert Adahatt      Calum E. J. Jetter

John Aulberson      Zach Waryp





**Brown, Deborah J. (CMS)**

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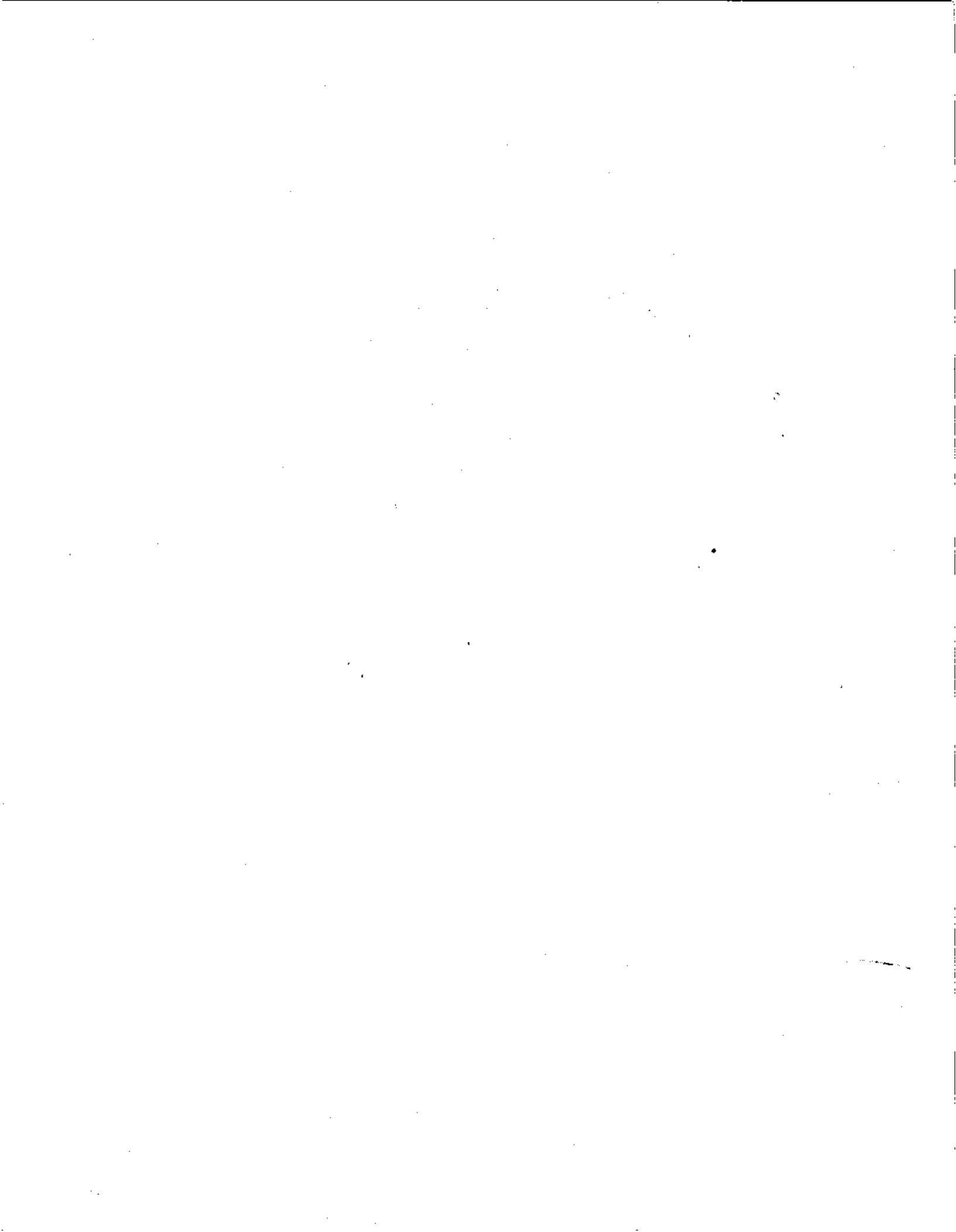
**From:** Chadwick, Alpheus K. (CMS/OL)  
**Sent:** Thursday, October 08, 2009 3:16 PM  
**To:** Smith, Amelia I. (CMS/OL)  
**Cc:** Brown, Deborah J. (CMS); Lewandowski, David S. (CMS/OL)  
**Subject:** FW: Names on the MA Gag letter

Please see below the names of the co-signers to the 9/30/09 MA letter.

---

**From:** Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]  
**Sent:** Thursday, October 08, 2009 3:14 PM  
**To:** Chadwick, Alpheus K. (CMS/OL)  
**Subject:** Names on the MA Gag letter

Michele Bachmann  
Rob Bishop  
Doug Lamobrn  
Lynn Westmoreland  
Cynthia Lummis  
  
Mike Pence  
John Kline  
Virginia Foxx  
Henry E. Brown, Jr.  
John Fleming  
Dan Burton  
Rodney Alexander  
Pete Olson  
John Abney Culberson  
Erik Paulsen  
Steve Scalise  
Zach Wamp  
Robert E. Latta  
Jerry Moran  
Brian Bilbray  
Robert Aderholt  
Gus M. Bilirakis  
Bob Inglis  
Joe Wilson  
~~Brian Bilbray~~  
Bob Goodlatte  
Aaron Shock  
Marsha Blackburn  
Lynn Jenkins  
Jo Bonner  
George Radanovich  
Paul Broun



Mark Souder

~~Tom Price~~

Wally Herger

Louie Gohmert

Mike Conaway

Todd Akin

Trent Franks

Jack Kingston

Cathy McMorris Rodgers

Jason Chaffetz

Blaine Luetkemeyer

Dan Lungren

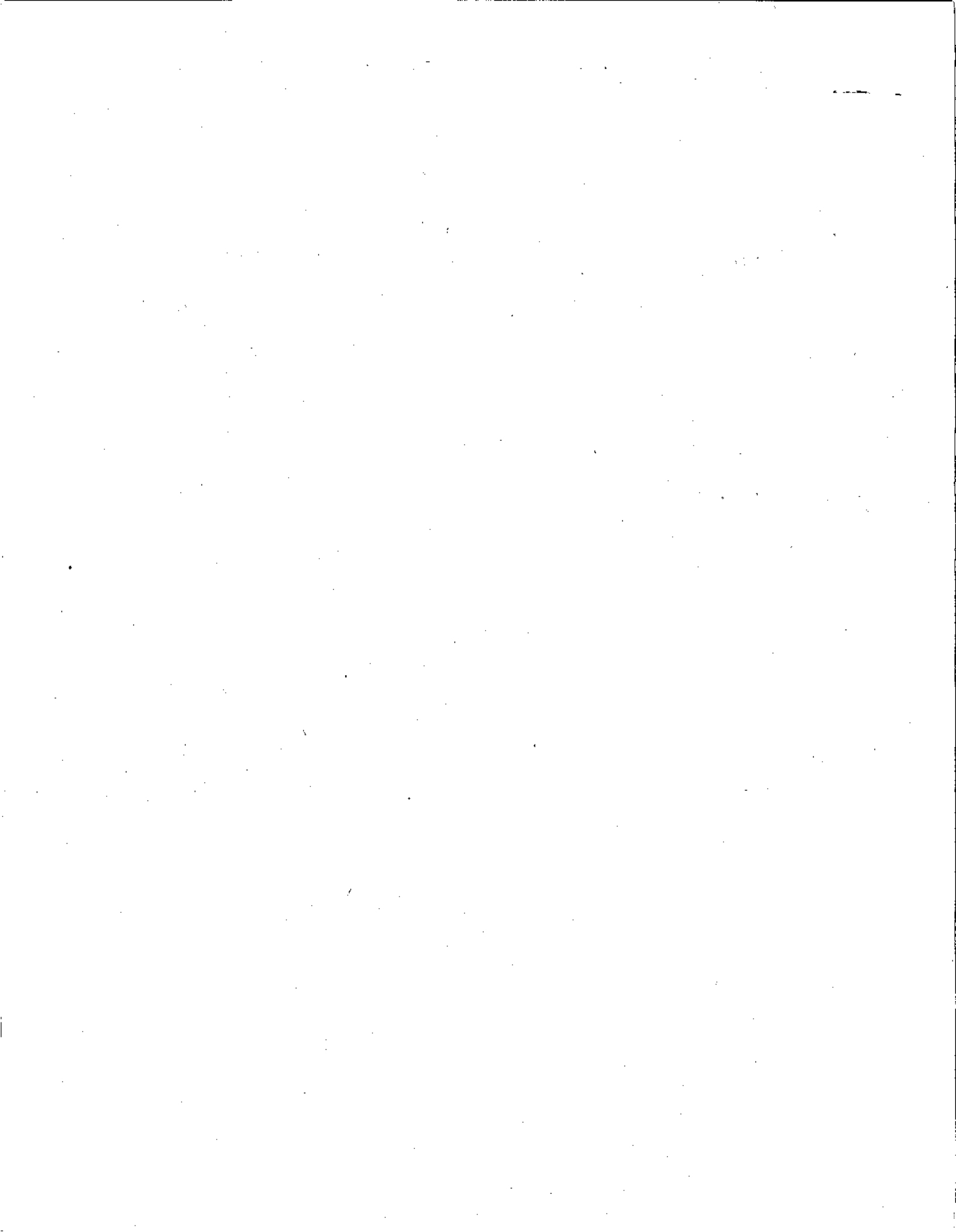
John Smimkus

Joe Pitts

Roscoe Bartlett

**Emily Henehan Murry**

Professional Staff Member  
Republican Study Committee (RSC)  
Office of Rep. Tom Price, M.D., *Chairman*  
424 Cannon Building  
202-225-4501





NOV 08 2013

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

Dear Senator Price:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CY 2014 OPPS 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 issues raised in this letter, in addition to other 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 OPPS 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,

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



**NOV 08 2013**

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

Dear Senator Gingery:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) 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 "Christina Ritter", written over a faint circular stamp.

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



**NOV 08 2013**

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

Dear Senator Roe:

Thank you for your letter regarding our proposal to package “skin substitutes” as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare





**NOV 08 2013**

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

Dear Senator Benishek:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) 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 "Christina Smith Ritter".

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



**NOV 08 2013**

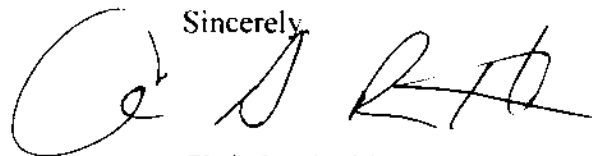
The Honorable Andy Harris, MD  
U.S. House of Representatives  
Washington, DC 20515

Dear Senator Harris:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

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Sincerely,  


Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



**NOV 08 2013**

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

Dear Senator Cassidy:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) 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, appearing to read "C. Ritter".

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



NOV 08 2013

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

Dear Senator Ellmers:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) 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,

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare



**NOV 08 2013**

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

Dear Senator Reed:

Thank you for your letter regarding our proposal to package "skin substitutes" as a drug or biological that functions as a supply or device in a surgical procedure in the Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) 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 "Christina Ritter".

Christina Smith Ritter, Ph.D.  
Deputy Director  
Hospital and Ambulatory Policy Group  
Center for Medicare

**Congress of the United States**  
**Washington, DC 20515**

October 9, 2013

Honorable Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Administrator Tavenner:

We are writing this letter to support the Centers for Medicare and Medicaid Services' (CMS) efforts to promote efficiency in the delivery of healthcare services and long-term cost containment by packaging payment for skin substitutes used in advanced wound care in the 2014 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule. As stewards of our taxpaying constituents' dollars, we are committed to ensuring public programs such as Medicare are administered in the most efficient manner. We believe this proposal will reduce waste, extending the solvency of the program.

Under the current system, CMS reimburses skin substitutes on a per square centimeter basis. The use of "size appropriate" skin substitutes should have minimized cost.

However, some manufacturers of the products in the skin substitute category have taken advantage of this reimbursement system by offering their products in only one size, which is fifteen to twenty times larger than that needed to cover the average size wound. In the hospital outpatient setting alone, this has resulted in an estimated \$75M in wasted product and lost taxpayer dollars in CY2011. In the physician setting, considerable waste also occurs. Your proposal represents an important step in reducing this waste by removing the incentive to use skin substitutes significantly larger than the size needed to care for a Medicare beneficiary's wound.

Other comments from industry stakeholders may propose a payment structure based on how a product is regulated by the Food and Drug Administration (FDA). However, the FDA regulates all of the skin substitutes covered by Medicare in some way. The regulatory pathway that a particular product takes to market should not be relevant for payment. The FDA determines how a product is to be regulated. The pathway taken does not necessarily correlate with clinical effectiveness. For example, some products regulated as tissues have been shown to heal wounds more rapidly and more effectively than other products regulated as devices. Therefore, no product should be exempted from the packaging proposal based on its regulatory status.

We further understand that some stakeholders have expressed concerns that the proposed packaging policy would undermine the provider's ability to treat large and complex wounds. With only one adult bundled price, hospital outpatient centers may opt to use



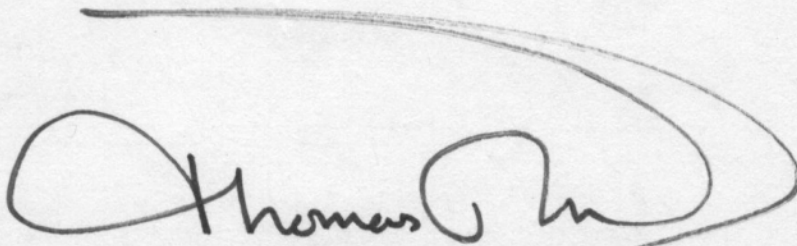
less effective products that are offered at a lower price, particularly if the wound is large and difficult to treat. In order to address these concerns, we urge you to create a tiered packaging structure based on wound size that would adequately reimburse providers for the treatment of larger wounds, such as advanced venous leg ulcers.

At this time in history, with continuing financial challenges and an aging population, it is more important than ever to act now to eliminate wasted dollars from our healthcare system, a system that is already overburdened. We support you in your efforts to promote efficiency and cost-containment in the delivery of healthcare services and maximize the effectiveness of taxpayers' contributions to Medicare. As you finalize the CY2014 OPPS rule, we ask that you continue these efforts while also taking into account the need to protect beneficiaries' access to the most appropriate treatment for large and complex wounds. Tiered packaging based on wound size is a more refined approach that will allow for the most effective product to be used on each wound, while significantly reducing waste in the Medicare program.

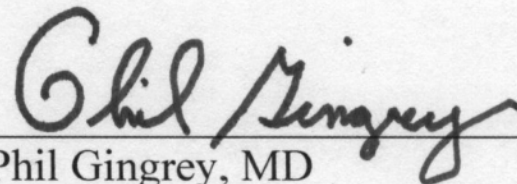
Due to the substantial and ongoing nature of the wastage that has occurred with certain skin substitutes over the years, it is imperative that you make these proposed payment changes as soon as possible. Thank you for your attention to this important matter.

We look forward to your positive response.

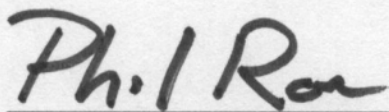
Sincerely,



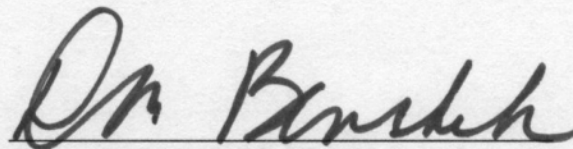
Tom Price, M.D.  
Member of Congress



Phil Gingrey, MD  
Member of Congress

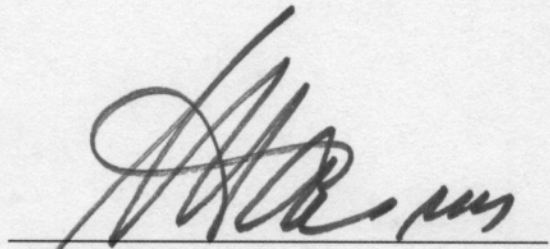


Phil Roe, MD  
Member of Congress



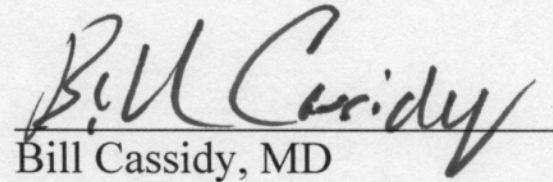
Dan Benishek, MD  
Member of Congress





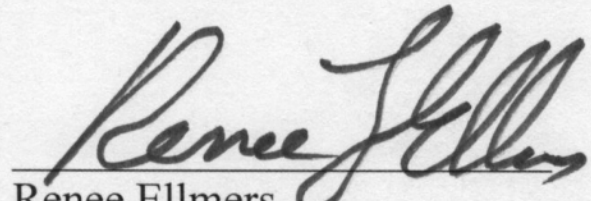
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Andy Harris, MD  
Member of Congress




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Bill Cassidy, MD  
Member of Congress



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Renee Ellmers  
Member of Congress



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Tom Reed  
Member of Congress





NOV 19 2013

*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 total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

We have adopted a process to consider and, as appropriate, revise values for all codes considered under the potentially misvalued codes initiative. Under that process, we establish values for misvalued codes on an interim basis in the final rule subject to public comment. We consider public comments received on the interim values in the final rule and respond to those comments in the final rule for the following year.

Although CMS did not include the AMA RUC's recommended values or its own proposed values for hip and knee replacements in the CY 2014 PFS proposed rule, CMS has met with physicians representing hip and knee replacement surgeons in order to understand their concerns about the AMA RUC recommendations. CMS is considering the issues they have raised to us as we consider interim values for these surgical services for CY 2014.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program. 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.

Marilyn Tavenner



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

NOV 19 2013

The Honorable Randy Neugebauer  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Neugebauer:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

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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



*Administrator*  
Washington, DC 20201

NOV 19 2013

The Honorable Marlin Stutzman  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Stutzman:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

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Sincerely,

A handwritten signature in cursive script that reads "Marilyn Tavenner".

Marilyn Tavenner



NOV 19 2013

Administrator  
Washington, DC 20201

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

Dear Representative Ruppertsberger:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

We have adopted a process to consider and, as appropriate, revise values for all codes considered under the potentially misvalued codes initiative. Under that process, we establish values for misvalued codes on an interim basis in the final rule subject to public comment. We consider public comments received on the interim values in the final rule and respond to those comments in the final rule for the following year.

Although CMS did not include the AMA RUC's recommended values or its own proposed values for hip and knee replacements in the CY 2014 PFS proposed rule, CMS has met with physicians representing hip and knee replacement surgeons in order to understand their concerns about the AMA RUC recommendations. CMS is considering the issues they have raised to us as we consider interim values for these surgical services for CY 2014.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program. 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 19 2013

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

Dear Representative Kind:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

We have adopted a process to consider and, as appropriate, revise values for all codes considered under the potentially misvalued codes initiative. Under that process, we establish values for misvalued codes on an interim basis in the final rule subject to public comment. We consider public comments received on the interim values in the final rule and respond to those comments in the final rule for the following year.

Although CMS did not include the AMA RUC's recommended values or its own proposed values for hip and knee replacements in the CY 2014 PFS proposed rule, CMS has met with physicians representing hip and knee replacement surgeons in order to understand their concerns about the AMA RUC recommendations. CMS is considering the issues they have raised to us as we consider interim values for these surgical services for CY 2014.

I appreciate your interest in this important issue as we work toward our mutual goal of strengthening the Medicare program. 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



*Administrator*  
Washington, DC 20201

NOV 19 2013

The Honorable Trey Radel  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Radel:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

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Although CMS did not include the AMA RUC's recommended values or its own proposed values for hip and knee replacements in the CY 2014 PFS proposed rule, CMS has met with physicians representing hip and knee replacement surgeons in order to understand their concerns about the AMA RUC recommendations. CMS is considering the issues they have raised to us as we consider interim values for these surgical services for CY 2014.

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Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner".

Marilyn Tavenner



*Administrator*  
Washington, DC 20201

NOV 19 2013

The Honorable Vern Buchanan  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Buchanan:

Thank you for your letter regarding Medicare payment for total knee and total hip replacements under the Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) greatly appreciates your bringing these concerns to our attention.

The CMS is reviewing payment for total and hip and knee replacements under the potentially misvalued code initiative. This initiative was developed in response to concerns raised by Congress, the Medicare Payment Advisory Commission, and other stakeholders. We identified these services as potentially misvalued in our calendar year (CY) 2012 Medicare PFS final rule, along with many other services, because these are high expenditure services that had not been reviewed since CY 2006. Under the potentially misvalued code initiative, CMS reviews recommendations made to us by American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) as well as recommendations made by other stakeholders when available. For codes being reviewed under the potentially misvalued code process, we typically do not receive AMA RUC recommendations in time for us to fully review them and include our proposals in the proposed rule.

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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

**Congress of the United States**  
**Washington, DC 20515**

October 15, 2013

RECEIVED

Honorable Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201

OCT 24 2013

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

Dear Administrator Tavenner:

We are writing to express our concern about the potential for the Centers for Medicaid & Medicare Services (CMS) to make significant cuts in Medicare reimbursement for total hip and knee replacement procedures in 2014 without adequate public notice and comment opportunity.

We have long believed that CMS policy should be shaped by careful consideration of public comments. We believe doctors who perform these procedures should have an opportunity to examine CMS's recommendations and underlying data and offer their analysis and comments before any rate changes go into effect. When considering rate changes, it is important to keep in mind that Medicare payments for hip and knee replacement procedures have not kept up with inflation. In real dollars, the payment rate has decreased 20% over the last 10 years.

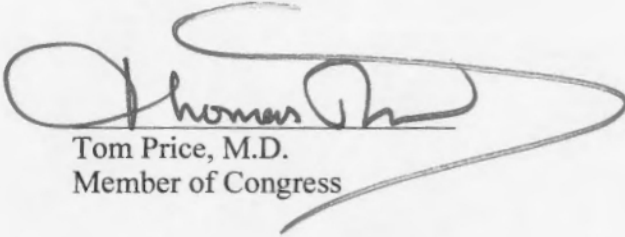
This issue has far-reaching implications for patient care. Total hip and total knee replacement surgery is highly effective, provides a net economic benefit to society by virtue of eliminating the indirect costs associated with the disability of severe hip and knee arthritis, and transforms the lives of patients so afflicted from dependency and immobility to independence and pain-free activity. If Medicare cuts physician payment for total hip and knee replacement surgery, beneficiary access will be severely limited. Medicare cuts would accelerate and exacerbate the trend of physicians opting out of Medicare or reducing the number of Medicare patients they are able to care for, as was recently reported in the Wall Street Journal. Limiting access of the most vulnerable segment of our society by cuts in Medicare reimbursement for these transformative and cost saving procedures is bad public policy.

CMS should not adopt significant Medicare payment reductions without providing meaningful notice and comment opportunity to doctors and the Medicare beneficiaries they serve. This is especially important for total hip and knee replacement procedures given the number of seniors who need this surgery currently and the increasing number who will need it in the future. Thank you for your consideration in this matter.

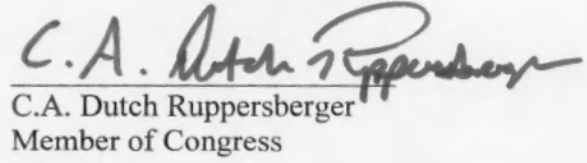
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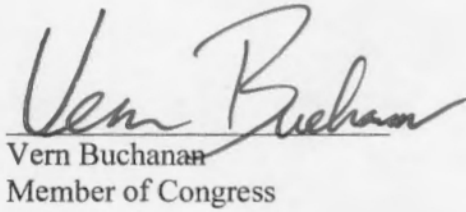
Sincerely,



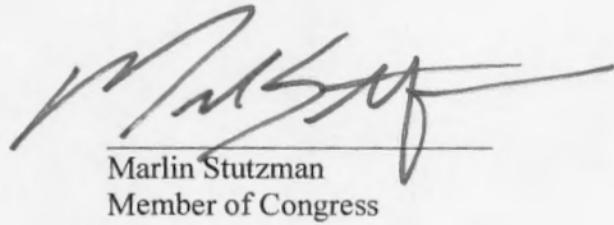
Tom Price, M.D.  
Member of Congress



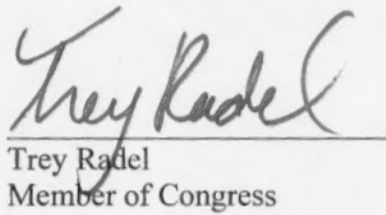
C.A. Dutch Ruppberger  
Member of Congress



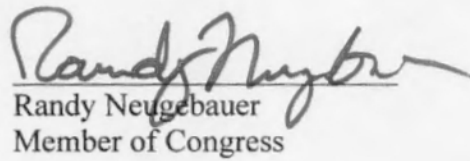
Vern Buchanan  
Member of Congress



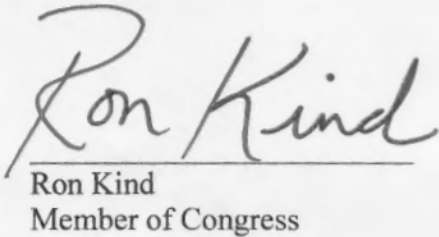
Marlin Stutzman  
Member of Congress



Trey Radel  
Member of Congress



Randy Neugebauer  
Member of Congress



Ron Kind  
Member of Congress

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**

**Correspondence Cover Sheet**

**Doc ID:** 112920104050      **Owner:** OL  
**Assigned To:** OL      **Status:** Closed

Created By	Date	Notes
Latasha Douglas	11/29/2010 5:15:09 PM	To OL for processing. NOTE: Congressman would like to meet before the end of 2010.
Beverly Massey	11/29/2010 5:42:23 PM	I am assigning this meeting request to Al Chadwick in OL.
Al Chadwick	12/7/2010 4:27:04 PM	Meeting acceptance pending with the Dept.
Zunaira Khalid	3/2/2011 11:01:49 AM	Per Al Chadwick, Maria Martino in OL attended this meeting with Don Berdwick and Rep. Price on 2/17/11. For any further questions, please contact Maria Martino at 202-690-5512.

Treat as an original



RECEIVED

NOV 29 2010

OSORA, DIVISION  
OF CORRESPONDENCE  
MANAGEMENT

**Fax Cover Sheet**  
**Congressman Tom Price**  
**6<sup>th</sup> District of Georgia**  
**424 Cannon House Office Building**  
**Washington, DC 20515**  
**Phone: (202) 225-4501**  
**Fax: (202) 225-4656**

**To: Dr. Donald Berwick**

**From: Emily Henehan Murry**

**Comments: Attn: Al Chadwick**

**Number of Pages including Cover Sheet: 3**

**TOM PRICE, M.D.**  
6TH DISTRICT, GEORGIA

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424 CANNON HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515  
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100 NORTH STREET, SUITE 150  
CANTON, GA 30114  
(678) 493-6176

[www.house.gov/tomprice](http://www.house.gov/tomprice)



**Congress of the United States**  
**House of Representatives**

November 29, 2010

COMMITTEE ON  
FINANCIAL SERVICES  
SUBCOMMITTEES:  
CAPITAL MARKETS  
DEPUTY RANKING MEMBER  
DOMESTIC MONETARY POLICY AND  
TECHNOLOGY  
FINANCIAL INSTITUTIONS AND  
CONSUMER CREDIT

COMMITTEE ON  
EDUCATION AND LABOR  
SUBCOMMITTEES:  
WORKFORCE PROTECTIONS  
HEALTH, EMPLOYMENT, LABOR AND PENSIONS  
RANKING MEMBER

REPUBLICAN STUDY COMMITTEE  
CHAIRMAN

DEPUTY WHIP

Dr. Donald Berwick  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244

Dear Dr. Berwick:

At the Senate Finance Committee hearing on November 17, 2010 you offered to meet with any Member of Congress who reaches out on an individual level.<sup>i</sup>

In your remarks at the Senate Finance hearing, you stated "I want to have dialogue with you and all the Members of Congress...any request at an individual level to meet with any Member of Congress that's come my way I have said yes to and done it and I look forward to ongoing dialogue and exchange with this committee and all Members of Congress, it's my job to do that."<sup>ii</sup>

Thank you for your stated desire for ongoing dialogue and exchange with Congressional committees and any Member of Congress.

As a practicing physician for over two decades, author of a comprehensive health care reform proposal, H.R. 3400, the Empowering Patients First Act, and Chairman of the Republican Study Committee (RSC), I believe that an in-depth discussion with you on your work at the Center for Medicare and Medicaid Services, specifically as it relates to patient-centered quality care, would be beneficial to our work on health care in the 112th Congress.

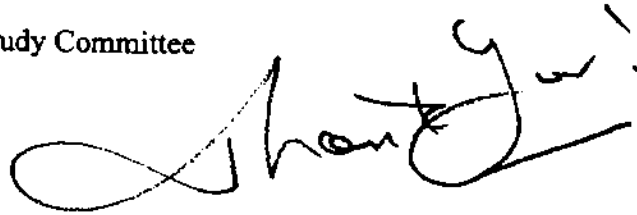
Many are truly concerned about your statement in June 2009, that "the decision is not whether or not we will ration care – the decision is whether we will ration with our eyes open,"<sup>iii</sup> the arguments in your book, *Escape Fire*, and statement in 2006 that Britain's National Health Service (NHS) "is not just a national treasure; it is a global treasure."<sup>iv</sup>

It is my desire that we may work together to put patients and doctors, rather than the federal bureaucracy, in charge of their personal health care decisions. I urge you to work with Congress and follow through on the Administration's promise of an "an unmatched level of transparency, participation and accountability across the entire Administration."<sup>v</sup>

Please follow up with my senior Health Legislative Assistant, Emily Murry, in my office at 202-225-9286 or [emily.murry@mail.house.gov](mailto:emily.murry@mail.house.gov), to schedule a meeting before the end of the year.

Yours truly,

  
Rep. Tom Price, M.D.  
Chairman, U.S. House Republican Study Committee



<sup>i</sup> "The United States Committee on Finance: Hearings – Strengthening Medicare and Medicaid: Taking Steps to Modernize America's Health Care System," November 17, 2010, Senate Finance web site, <http://finance.senate.gov/hearings/watch/?id=280ebc81-5056-a032-5254-1010c1e9b945>, accessed November 23, 2010

<sup>ii</sup> "Donald Berwick's Offer," November 19, 2010, YouTube web site, <http://www.youtube.com/watch?v=jrUzbR172ek>, accessed November 23, 2010

<sup>iii</sup> "Rethinking Comparative Effectiveness Research," An Interview with Dr. Donald Berwick, Biotechnology HealthCare, June 2009, Biotechnology HealthCare web site, <http://www.biotechnologyhealthcare.com/journal/fulltext/6/2/BH0602035.pdf>, accessed November 23, 2010

<sup>iv</sup> "Steadying the NHS" by Donald Berwick and Sheila Leatherman, BMJ July 29, 2006, p. 255

<sup>v</sup> "Statement from the President on Sunshine Week," the White House press release, March 16, 2010, White House web site, <http://www.whitehouse.gov/the-press-office/statement-president-sunshine-week>, accessed November 23, 2010