115TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 115–446
Part 1

INDEPENDENCE AT HOME DEMONSTRATION IMPROVEMENT AND EXTENSION ACT OF 2017

DECEMBER 6, 2017.—Ordered to be printed

Mr. WALDEN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 3263]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3263) to amend title XVIII of the Social Security Act to extend the Medicare independence at home medical practice demonstration program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Independence at Home Demonstration Improvement and Extension Act of 2017".

SEC. 2. EXTENDING THE MEDICARE INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

(a) IN GENERAL.—Section 1866E of the Social Security Act (42 U.S.C. 1395cc–5) is amended—

(1) in subsection (e)—

(A) in paragraph (1)—

(i) by striking "An agreement" and inserting "Agreements"; and

(ii) by striking "5-year" and inserting "7-year"; and

(B) in paragraph (5)—

(i) by striking "10,000" and inserting "15,000"; and

(ii) by adding at the end the following new sentence: "An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 2(a)(1)(B) of the Independence at Home Demonstration Improvement and Extension Act of 2017 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program.";

(2) in subsection (g), in the first sentence, by inserting ", including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)" after "under the demonstration program"; and

(3) in subsection (i)(1)(A), by striking "will not receive an incentive payment for the second of 2" and inserting "did not achieve savings for the third of 3".

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(3) shall take effect as if included in the enactment of Public Law 111–148.

PURPOSE AND SUMMARY

H.R. 3263 was introduced on July 17, 2017, by Rep. Michael C. Burgess, M.D. (R–TX). H.R. 3263 would extend the Independence at Home Medical Practice Demonstration Program (IAH), which provides a home-based primary care benefit to high-need Medicare beneficiaries with multiple chronic conditions. The program is designed to allow beneficiaries to stay in their homes instead of institutionalized settings, avoiding unnecessary hospitalizations, ER visits, and nursing home use. H.R. 3263 would extend the program for two additional years.

BACKGROUND AND NEED FOR LEGISLATION

Currently in its fifth year, the Centers for Medicare and Medicaid Services (CMS) has evaluated the Independence at Home program's success and found it to have saved money for the Medicare program in the first and second years (year three data is still be analyzed.). Under statute, the demonstration in total must generate savings and any practice that does not generate savings of 5 percent faces removal from the demonstration. With statutory authority for the demonstration ending, this extension will provide CMS with additional time to evaluate the program's effectiveness and any changes that may be needed. The extension will also provide Congress additional time and information necessary to weigh the benefits to program savings and beneficiary care that the demonstration has brought and if the program should be changed, extended or made permanent.

COMMITTEE ACTION

On July 20, 2017, the Subcommittee on Health held a hearing on H.R. 3263. The hearing was entitled Examining Bipartisan Legislation to Improve the Medicare Program. The Subcommittee received testimony from:

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

On September 13, 2017, the Subcommittee on Health met in open markup session and forwarded H.R. 3263, without amendment, to the full Committee by a voice vote. On October 4, 2017, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 3263, as amended, favorably reported to the House by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 3263 reported.

OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, the Committee held a hearing and made findings that are reflected in this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that H.R. 3263 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

H.R. 3263—A bill to amend title XVIII of the Social Security Act to extend the Medicare Independence at Home Medical Practice Demonstration program

Summary: H.R. 3263 would extend the Independence at Home (IAH) program for two years, through late fiscal year 2019, and would increase the aggregate cap on the number of Medicare beneficiaries served by participating providers from 10,000 to 15,000. CBO estimates that enacting H.R. 3263 would increase direct spending by $16 million over the 2018–2027 period.

Enacting H.R. 3263 would affect direct spending; therefore, pay-as-you-go procedures apply. The legislation would not affect revenues.

CBO estimates that enacting H.R. 3263 would not increase net direct spending or on-budget deficits by more than $5 billion in one or more of the four consecutive 10-year periods beginning in 2028.

H.R. 3263 contains no intergovernmental or private sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 3263 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018–2022	2018–2027
INCREASES IN DIRECT SPENDING												
Estimated Budget Authority ..	0	2	7	7	0	0	0	0	0	0	16	16
Estimated Outlays	0	2	7	7	0	0	0	0	0	0	16	16

Basis of estimate: Primary care services provided in a number of settings, including a patient's home, are covered by the Medicare program. The IAH program was established to test whether providing a financial incentive—bonus payments—for providers to deliver primary care services in a patient's home would reduce Medicare spending and improve the quality of care. Providers participating in the IAH program receive a bonus payment if their practice meets quality standards and the average cost of Medicare benefits for its patients is less than 95 percent of the average cost of such benefits for similar patients in the community.[1]

Those bonus payments would add to federal costs. The ultimate budgetary effect would depend on whether they resulted in offsetting reductions in Medicare spending. However, determining that the patients served by participating providers have Medicare costs that, on average, are below that 95 percent level does not necessarily indicate that the IAH program reduces Medicare spending, because it does not indicate that the program has changed Medi-

[1] Measuring the cost of similar patients in the community has proved to be a very difficult technical challenge. As a result, each time the evaluators have analyzed the data for a performance year, they have recommended making substantial changes to how those costs will be estimated for a subsequent performance year. Participating providers have been given the choice of continuing to use the existing method or switching to the newly developed method.

care's costs for beneficiaries served by participating providers. Expanding the use of home-based services through the IAH program would probably increase the use of certain services, but would ultimately reduce Medicare spending if the resulting change in practice patterns lowered health care costs or if the IAH program shifted market share from higher-cost to lower-cost providers, as long as the resulting savings amounted to more than the bonuses paid through the program. To date, interim evaluations of the IAH program have not assessed whether such changes have occurred. In the absence of such information, CBO has no basis for concluding whether the bonus payments offered through the IAH program have spurred participating providers to make changes affecting Medicare spending.

Further, the bonus payments, as designed, are not targeted exclusively at inducing changes to reduce spending. Instead, providers with relatively low costs would qualify for bonuses whether they make any changes in the way they provide care or not. Similarly, providers who do make changes, but do not lower spending by enough to qualify for a bonus would not receive one. On the basis of the bonus payments made to date, CBO estimates that Medicare would make annual bonus payments to participating providers that average about $5 million per 10,000 beneficiaries for each additional year of the demonstration. Taking into account both the 5,000 increase in the cap on the number of participating beneficiaries and the effect of interactions between changes in spending in the fee-for-service sector and payment rates in the Medicare Advantage (MA) program, CBO estimates that the bill's changes to the IAH program would increase Medicare spending by $16 million over the 2018–2027 period.

Pay-As-You-Go Considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 3263, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON OCTOBER 4, 2017

	By fiscal year, in millions of dollars—											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018–2022	2018–2027
	NET INCREASE IN THE DEFICIT											
Statutory Pay-As-You-Go Impact	0	2	7	7	0	0	0	0	0	0	16	16

Increase in long–term direct spending and deficits: CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2028.

Intergovernmental and private–sector impact: H.R. 3263 contains no intergovernmental or private-sector mandates as defined in UMRA.

Previous CBO estimate: On August 1, 2017, CBO produced an estimate for S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, as ordered reported by the Senate Committee on Finance on May 18,

2017. The provisions in S. 870 extending the Independence at Home program are identical to H.R. 3263 and CBO's estimate of their budgetary effects is the same.

Estimate prepared by: Federal Costs: Colin Yee; Impact on State, Local, and Tribal Governments and the Private Sector: Amy Petz.

Estimate approved by: Theresa Gullo, Assistant Director for Budget Analysis

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to extend the Independence at Home Medical Practice Demonstration Program.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 3263 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 3263 contains no earmarks, limited tax benefits, or limited tariff benefits.

DISCLOSURE OF DIRECTED RULE MAKINGS

Pursuant to section 3(i) of H.Res. 5, the Committee finds that H.R. 3263 contains no directed rule makings.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 provides that the Act may be cited as the "Independence at Home Demonstration Improvement and Extension act of 2017."

Section 2. Extending the Medicare Independence at Home Demonstration Program

Section 2 would extend the Medicare Independence at Home Demonstration Program for two additional years and raise the limit on the number of practices allowed to participate in the demonstration program from 10,000 to 15,000. In addition, the section would expand the scope of the required evaluation and report to Congress to include an evaluation of the use of electronic health information systems. Finally, the section would change the conditions under which the Department of Health and Human Services (HHS) must terminate an agreement with an independent at home medical practice to require HHS to terminate such an agreement if it did not achieve savings for three consecutive years.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * * * *

INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

SEC. 1866E. (a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the "demonstration program") to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and

accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

(A) reducing preventable hospitalizations;

(B) preventing hospital readmissions;

(C) reducing emergency room visits;

(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

(F) reducing the cost of health care services covered under this title; and

(G) achieving beneficiary and family caregiver satisfaction.

(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

(A) IN GENERAL.—The term "independence at home medical practice" means a legal entity that—

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

(ii) is organized at least in part for the purpose of providing physicians' services;

(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) PHYSICIAN.—The term "physician" includes, except as the Secretary may otherwise provide, any individual

who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) PAYMENT METHODOLOGY.—

(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are esti-

mated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

(d) APPLICABLE BENEFICIARIES.—

(1) DEFINITION.—In this section, the term "applicable beneficiary" means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

(A) is entitled to benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

(D) within the past 12 months has had a nonelective hospital admission;

(E) within the past 12 months has received acute or subacute rehabilitation services;

(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

(G) meets such other criteria as the Secretary determines appropriate.

(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

(e) IMPLEMENTATION.—

(1) STARTING DATE.—The demonstration program shall begin no later than January 1, 2012. [An agreement] *Agreements* with an independence at home medical practice under the demonstration program may cover not more than a [5-year] *7-year* period.

(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

(A) located in high-cost areas of the country;

(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

(C) use electronic medical records, health information technology, and individualized plans of care.

(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed ⟦10,000⟧ *15,000 An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 2(a)(1)(B) of the Independence at Home Demonstration Improvement and Extension Act of 2017 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program.*

(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(f) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program*, including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)*. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under sec-

tion 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) TERMINATION.—

(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice [will not receive an incentive payment for the second of 2] *did not achieve savings for the third of 3* consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

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EXCHANGE OF LETTERS WITH ADDITIONAL COMMITTEES OF REFERRAL

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
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December 5, 2017

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden,

I am writing with respect to H.R. 3263, to amend title XVIII of the Social Security Act to extend the Medicare independence at home medical practice demonstration program, on which the Committee on Ways and Means was granted the primary referral.

As a result of your having consulted with us on provisions in H.R. 3263 that fall within the Rule X jurisdiction of the Committee on Ways and Means, I agree to waive formal consideration of this bill so that it may move expeditiously to the floor. The Committee on Ways and Means takes this action with the mutual understanding that we do not waive any jurisdiction over the subject matter contained in this or similar legislation, and the Committee will be appropriately consulted and involved as the bill or similar legislation moves forward so that we may address any remaining issues that fall within our jurisdiction. The Committee also reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation, and requests your support for such request.

Finally, I would appreciate your response to this letter confirming this understanding, and would ask that a copy of our exchange of letters on this matter be included in the *Congressional Record* during floor consideration of H.R. 3263.

Sincerely,

Kevin Brady
Chairman

cc: The Honorable Paul Ryan, Speaker
The Honorable Richard E. Neal
The Honorable Frank Pallone
Thomas J. Wickham, Jr., Parliamentarian

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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December 5, 2017

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

Thank you for your letter regarding H.R. 3263, a bill to extend the Medicare Independence at home Medical Practice Demonstration program, on which the Committee on Ways and Means was granted the primary referral.

I appreciate your agreeing to waive formal consideration of H.R. 3263 in order to allow the bill to move expeditiously to the House floor.

I agree that by foregoing consideration on H.R. 3263 at this time, the Committee on Ways and Means does not waive any jurisdiction over subject matter contained in this or similar legislation, and that the Committee will be appropriately consulted and involved as this bill or similar legislation moves forward. I also agree that the Committee reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation, and I will support any such request.

Finally, I will include a copy of your letter and this response in the Congressional Record during the floor consideration of this bill.

Sincerely,

Greg Walden
Chairman

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