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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
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January 6, 2026

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Subcommittee on Health Hearing on January 8, 2026

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Thursday, January 8, 2026, at 10:15 am (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Legislative Proposals to Support Patient Access to Medicare Services." The Subcommittee intends to discuss the following pieces of legislation:

- H.R. 1703, Choices for Increased Mobility Act of 2025 (Rep. Joyce – PA)
- H.R. 2005, DMEPOS Relief Act of 2025 (Rep. Miller-Meeks)
- H.R. 2172, Preserving Patient Access to Home Infusion Act (Rep. Buchanan)
- H.R. 2477, Portable Ultrasound Reimbursement Equity Act of 2025 (Rep. Van Duyne)
- H.R. 2902, Supplemental Oxygen Access Reform (SOAR) Act of 2025 (Rep. Valadao)
- H.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage. (Rep. McClellan)
- H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025 (Rep. Hudson)
- H.R. 5347, Health Care Efficiency Through Flexibility Act (Rep. Buchanan)
- H.R. 6210, Senior Savings Protection Act (Rep. Matsui)
- H.R. 6361, Ban AI Denials in Medicare Act (Rep. Landsman)

II. WITNESSES

- **Susan Van Meter**, President, American Clinical Laboratory Association
- **Connie Sullivan**, President and CEO, National Home Infusion Association
- **Thomas Ryan**, President and CEO, American Association for Homecare
- **David Lipschutz, JD,** Attorney and Co-Director of Law and Policy, Center for Medicare Advocacy

III. BACKGROUND

This legislative hearing will continue the Committee's focus on modernizing and strengthening the Medicare program to sustain and enhance seniors' access to care. Specifically, the hearing will examine several Medicare payment policies, including legislation that would reform the Medicare clinical laboratory fee schedule (CLFS), Medicare's payment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and Medicare's home infusion therapy benefit, among other policies.

Medicare Clinical Laboratory Fee Schedule

Under Part B, Medicare covers clinical laboratory tests that are reasonable and necessary for the diagnosis and treatment of disease when they are ordered by physicians or other qualified practitioners and performed in a Clinical Laboratory Improvement Amendments-certified laboratory.[1] Clinical laboratory tests are generally paid at rates established under the CLFS unless they require the work of a physician or are bundled with other services (e.g., tests furnished alongside other services in an institutional setting).[2] Medicare beneficiaries do not pay cost sharing for clinical laboratory tests under the CLFS.[3] Payments under this fee schedule totaled approximately $9.3 billion in calendar year 2024.[4]

In 2014, the Protecting Access to Medicare Act (PAMA) was enacted, which included, among other provisions, new requirements for the Centers for Medicare & Medicaid Services (CMS) when establishing Medicare payment rates for clinical laboratory tests under the CLFS.[5]

Prior to PAMA, Medicare's CLFS payment rates were generally based on local, historical laboratory charges that were updated based on inflation rates and capped at national limitation amounts.[6] Research suggested that the Medicare program could achieve savings by revising its payment structure for clinical laboratory tests. A 2013 report from the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that in 2011, "Medicare paid between 18 and 30 percent more than other insurers for 20 high-volume and/or high-expenditure lab tests. Medicare could have saved $910 million, or 38 percent, on these lab tests if it had paid providers at the lowest established rate in each geographic area."[7]

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[1] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 9: Mandated report: Assessing the impact of recent changes to Medicare's clinical laboratory fee schedule payment rates* (June 2021), https://www medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch9_medpac_report_to_congress_sec.pdf.
[2] *Id.*
[3] MedPAC, Payment Basics, *Clinical Laboratory Services Payment System* (Nov. 2025), https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_clinical_lab_FINAL_SEC.pdf.
[4] CTRS. FOR MEDICARE & MEDICAID SERVICES (CMS), *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (June 18, 2025), https://www.cms.gov/oact/tr/2025.
[5] Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, (2014).
[6] MedPAC, *supra* note 1.
[7] DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS), OFFICE OF INSPECTOR GENERAL, *Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings* (June 2013), https://oig hhs.gov/documents/evaluation/3037/OEI-07-11-00010-Complete%20Report.pdf.

The CLFS reforms included in PAMA were first implemented in 2018. Section 1834A of the Social Security Act requires that CMS establish CLFS payment for most clinical laboratory tests based on weighted median private payor rates, which are then updated every three years.[8] To establish private payor-based rates for tests under the CLFS, CMS collects from applicable laboratories information regarding each test's billing code, its final private payor rates during the data collection period, and the volume of tests furnished at each of those private payor rates.[9] Applicable laboratories then report this data to CMS during the data reporting period, which the agency uses to calculate the weighted median private payor rate for a particular test.[10] These rates are not updated by inflation and remain in effect for three years until CMS sets revised rates utilizing updated data reported by applicable laboratories.

Following PAMA's enactment and CMS's implementation of the private payor-based CLFS rates, Congress has repeatedly delayed the next data reporting period for applicable laboratories, as well as modified and extended the phase-in of the cap on annual payment reductions originally included in PAMA.[11] Under current law, as most recently modified in the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, applicable laboratories are set to report updated information to CMS for the January 1, 2019, to June 30, 2019, data collection period.[12] Laboratories will report this data between February 1, 2026, and April 30, 2026. The November 2025 continuing resolution also applied a 0 percent reduction cap until January 30, 2026, with the 15 percent reduction cap applying for the remainder of 2026.[13]

Since the first round of data reporting in 2017, some stakeholders—including laboratories, providers, hospitals, laboratory professionals, and diagnostic manufacturers—have expressed concern with the implementation of the CLFS reforms enacted in PAMA. Their concerns primarily center on the representativeness of the data submitted and used to calculate

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[8] CMS, *Clinical Laboratory Fee Schedule* (Nov. 24, 2025), https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs; *see also* 42 U.S.C. §1395m–1A(d) establishing a separate payment process for certain tests defined as "advanced diagnostic laboratory tests."

[9] CMS, *Summary of Private Payor Rate-Based Medicare Clinical Laboratory Fee Schedule-Updated* (Dec. 7, 2023), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2019-CLFS-PrivatePayor-RateBased-Summary.pdf; *see also* 42 U.S.C. 1395m-1(a)(8) establishing the private payors used for establishing rates for clinical laboratory test payment rates under the CLFS and includes health insurance issuers and group health plans, Medicare Advantage plans, and Medicaid managed care organizations; *see also* 42 U.S.C. 1395m-1(a)(2) establishing "applicable laboratories" such that they include laboratories that receive a majority of their revenue from 42 U.S.C. 1395m-1, 42 U.S.C. 1395l (h), or 42 U.S.C. 1395w–4; *see also* Protecting Access to Medicare Act of 2014, *supra* note 5 permitting the Secretary to establish low volume or low expenditure thresholds to exclude a laboratory from being considered an "applicable laboratory."

[10] CMS, *Summary of Private Payor Rate-Based Medicare Clinical Laboratory Fee Schedule-Updated* (Dec. 7, 2023), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2019-CLFS-PrivatePayor-RateBased-Summary.pdf.

[11] Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, (2019); *see also* Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, (2020); *see also* Protecting Medicare and American Farmers from Sequester Cuts Act, Pub. L. No. 117-71, (2021); *see also* Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, (2022); *see also* Further Continuing Appropriations and Other Extensions Act, 2024, Pub. L. No. 118-22, (2023); *see also* Continuing Appropriations and Extensions Act, 2025, Pub. L. No. 118-83, (2024).

[12] Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, Pub. L. No. 119-37, (2025).

[13] *Id.*

the private payor-based rates under the CLFS, as well as the administrative burden placed on laboratories and CMS by the data collection and reporting processes.[14]

Medicare Payment for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Under Part B, Medicare covers certain medical equipment and supplies for use in the home setting when they are reasonable and necessary to treat a beneficiary's illness or injury, and the beneficiary must pay a 20 percent coinsurance.[15] These items are covered under the DMEPOS benefit, for which spending totaled approximately $9.1 billion in calendar year 2024.[16]

Medicare generally pays for DMEPOS items and services either through the competitive bidding program (CBP) or under the DMEPOS fee schedule.[17] Payment categories under the DMEPOS fee schedule include inexpensive and other routinely purchased items, frequently serviced items, oxygen and oxygen equipment, items necessary for the effective use of DMEPOS, and capped rental items.[18]

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the HHS Secretary to implement CBPs for certain DMEPOS items and services.[19] As part of the conditions for awarding contracts under the CBP, the Secretary must ensure the supplier meets quality and financial standards, the total amounts paid are likely to be less than would be paid otherwise, and that beneficiaries maintain access to multiple suppliers in their area.[20] The Social Security Act allowed CMS to phase-in DMEPOS items into the CBP, and the agency did so beginning with Round 1 Areas (9 Metropolitan Statistical Areas (MSAs)), implemented in 2011, and Round 2 Areas (90 MSAs and the National Mail Order), implemented in 2013.[21] These initial rounds were subsequently recompeted through 2018, and no rounds were active in 2019 and 2020.[22]

During Round 2021, CMS bid 16 product categories in 130 competitive bidding areas (CBA). Non-invasive ventilators were ultimately removed from bidding due to the COVID-19 public health emergency, and 15 product categories (including 13 recompetes) were bid.[23] CMS noted that "[within] 130 CBAs, there were over 2,000 competitions and CMS received and

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[14] Letter from AdvaMed et al. to The Honorable Mike Johnson, The Honorable Hakeem Jeffries, The Honorable John Thune, and The Honorable Charles Schumer (Oct. 30, 2025), https://www.acla.com/wp-content/uploads/2025/10/2025-RESULTS-Act_Provider-Letter-10.30.25.pdf.
[15] MedPAC, Payment Basics, *Durable Medical Equipment, Prosthetics, Orthotics, And Supplies Payment System* (Nov. 2025), https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_DME_FINAL_SEC.pdf.
[16] CMS, *supra* note 4.
[17] MedPAC, *supra* note 15.
[18] *Id.*
[19] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, (2003).
[20] 42 U.S.C. § 1395w–3(b)(2).
[21] The final rule, "Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies," 90 Fed. Reg. 55342 (Dec. 2, 205).
[22] MedPAC, *supra* note 15.
[23] 90 Fed. Reg. 55342, s*upra* note 21.

reviewed over 49,000 bids. The Round 2021 contracts went into effect in 127 CBAs for off-the-shelf (OTS) back braces and OTS knee braces product categories, resulting in estimated Medicare savings of $934 million."[24] However, CMS did not award contracts in Round 2021 for the 13 product categories that were recompeted because the payment amounts yielded by the bids were not expected to achieve savings for the Medicare program.[25]

In the Calendar Year 2026 Home Health Prospective Payment System final rule, CMS finalized changes to the DMEPOS benefit, including the announcement of the next round of bidding under the CBPs for certain product categories.[26] The next round of the DMEPOS CBP will include the following categories, all of which will be included in the Nationwide Remote Item Delivery Program:[27]

- Class II Continuous Glucose Monitors (CGM) and Insulin Pumps
- Urological Supplies
- Ostomy Supplies
- Hydrophilic Urinary Catheters
- OTS Back Braces
- OTS Knee Braces
- OTS Upper Extremity Braces

CMS also finalized adjustments to the bidding methodology and parameters, as well as certain financial documentation requirements, among other changes.[28] The agency aims for this round of contracts and single payment amounts to go into effect by January 1, 2028.[29]

Medicare Home Infusion Therapy Benefit

In 2016, the 21st Century Cures Act (Cures Act) was enacted.[30] Section 5012 of the legislation established a home infusion therapy benefit under Medicare Part B to provide coverage of the service components of home infusion therapy (HIT), effective beginning on January 1, 2021. HIT "involves the parenteral administration of drugs or biologicals to an individual at home, outside of the hospital or clinic setting."[31]

The HIT benefit established in the Cures Act provides for Medicare coverage of the professional services associated with HIT. In addition to covering certain services through the HIT benefit, Medicare covers some elements of HIT under the DME benefit. The DME benefit

[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] CMS, Fact Sheet, *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program – Updates and Important Information* (Nov. 28, 2025), https://www.cms.gov/newsroom/fact-sheets/durable-medical-equipment-prosthetics-orthotics-supplies-competitive-bidding-program-updates.
[28] *Id.*
[29] *Id.*
[30] 21st Century Cures Act, Pub. L. No. 114 - 255, (2016).
[31] CMS, *Medicare Part B Home Infusion Therapy Services With The Use of Durable Medical Equipment* (Dec. 13, 2019), https://www.cms.gov/files/document/se19029.pdf.

includes coverage of the infusion drug, the DME (e.g., the external infusion pump and related equipment), and other non-drug supplies such as tubing or catheters.[32]

More specifically, section 1861(iii)(2) of the Social Security Act, as enacted by the Cures Act, provides coverage of the following items and services under the HIT benefit itself: professional services, training and education, remote monitoring, and monitoring services for the provision of the home infusion drug.[33] The Cures Act defined "home infusion drugs" as "a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment" and excluded insulin pump systems and self-administered drugs or biological on a self-administered drug exclusion list.[34]

The HIT benefit is furnished to beneficiaries by a "qualified home infusion therapy supplier" in the beneficiary's home. Theses suppliers must meet several requirements, including ensuring the safe and effective provision and administration of HIT on a 24/7 basis and be accredited by a CMS-approved organization, among other criteria.[35] Under current practice, the single payment under the HIT benefit may only be billed for days on which a professional is present in the patient's home and a home infusion drug is administered, known as an "infusion drug administration calendar day."[36]

In the February 2025 HIT Monitoring Report, a CMS-funded analysis examined recent HIT trends in Medicare. The report noted that "[from] Q1 2022 to Q2 2024, the quarterly average of HIT service visits was 7,437 visits. HIT service visits decreased from a high of 8,467 in Q1 2022 to 6,321 in Q2 2024," and the total number of HIT service recipients decreased from 1,309 in Q1 2022 to 1,081 in Q2 2024.[37] The report noted that there were 62 HIT supplier organizations providing these service visits in Q2 2024.[38]

IV. LEGISLATION

H.R. 1703, Choices for Increased Mobility Act of 2025 (Rep. Joyce – PA)

This bill would clarify payment rules for manual wheelchairs under Medicare Part B to specify that coverage of manual wheelchairs does not include expenses associated with the use of titanium or carbon fiber materials to construct the base of a wheelchair, allowing patients with Medicare Part B to pay out-of-pocket for wheelchair upgrades if they so choose.

H.R. 2005, DMEPOS Relief Act of 2025 (Rep. Miller-Meeks)

This legislation would require HHS to provide certain adjustments to Medicare payment for items of durable medical equipment that were formerly included in round 2021 of the

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[32] *Id.*
[33] 42 U.S.C. § 1395x(iii)(2).
[34] 42 U.S.C. § 1395x(iii)(3)(C).
[35] 42 U.S.C. § 1395x(iii)(3)(D).
[36] CMS, *supra* note 31.
[37] CMS, Report, *HIT Monitoring Report* (Feb. 2025), https://www.cms.gov/files/document/hitmonitoringreportfeb272025sxf508.pdf.
[38] *Id.*

Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) competitive bidding program.

H.R. 2172, Preserving Patient Access to Home Infusion Act (Rep. Buchanan)

This legislation would allow nurse practitioners and physician assistants to establish and review home infusion plans of care, provide for pharmacy services as a professional service under the HIT service benefit, require CMS to pay home infusion providers for each day they administer drugs to patients, modify the definition of "home infusion drug," and prohibit additional payment for certain supplies when furnished in conjunction with HIT.

H.R. 2477, Portable Ultrasound Reimbursement Equity Act of 2025 (Rep. Van Duyne)

This legislation would provide for separate payment for portable ultrasound transportation and set up services under Medicare, similar to payments provided for portable X-ray transportation and set up services.

H.R. 2902, Supplemental Oxygen Access Reform (SOAR) Act of 2025 (Rep. Valadao)

This legislation would reform Medicare's payment for oxygen and oxygen-related equipment, supplies, and services, removing them from the competitive bidding program and establishing separate payment for these items and services. The bill also provides for coverage of certain respiratory therapist services, requires the Secretary to adopt an electronic template to be completed by the prescribing practitioner to determine whether these items and services are reasonable and necessary, and establishes certain beneficiary notice requirements and protections for individuals receiving oxygen and oxygen-related items and services.

H.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage. (Rep. McClellan)

This legislation would require enrollee-level utilization reporting of supplemental benefits by Medicare Advantage plans.

H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025 (Rep. Hudson)

This legislation would reform Medicare's payment for certain clinical laboratory tests under the CLFS. The bill would require the Secretary to enter a contract with a "qualifying independent claims data entity" to provide CMS with data about private payor rates for purposes of calculating the weighted median private payor rate for widely available, non-ADLT clinical laboratory tests beginning in 2029. Payment rates for non-widely available, non-ADLT clinical laboratory tests would be established based on the reporting of private payor payment rates for clinical laboratory tests and the volume associated with that test to the Secretary for purposes of calculating the payment rate under the CLFS. The legislation would also cap annual rate reductions at 5 percent beginning in 2029.

H.R. 5347, Health Care Efficiency Through Flexibility Act (Rep. Buchanan)

This legislation would require the Secretary to make available certain collection types for quality measures that accountable care organizations (ACO) are required to report for performance years (PY) 2025 through 2029, including electronic clinical quality measures, Merit-based Incentive Payment System (MIPS) clinical quality measures, and Medicare clinical quality measures for ACOs participating in the Medicare Shared Savings Program. The bill would also require that the Secretary establish a reporting pilot program for digital quality measures for PYs 2028 through 2032.

H.R. 6210, Senior Savings Protection Act (Rep. Matsui)

This legislation would extend funding for the State Health Insurance Assistance Programs (SHIP), Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC), and a contract with an entity to inform older Americans about benefits available under Federal and State programs for fiscal years 2026 through 2030 at current funding levels.

H.R. 6361, Ban AI Denials in Medicare Act (Rep. Landsman)

This legislation would prohibit CMS from implementing the Wasteful and Inappropriate Services Reduction (WISeR) Model or any substantially similar model. The bill would also prohibit any future Center for Medicare & Medicaid Innovation models that would test prior authorization (including through the use of artificial intelligence) in traditional Medicare.

VI. STAFF CONTACTS

If you have questions regarding this hearing, please contact Annabelle Huffman of the Committee staff at (202) 225-3641.