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Medicare Smart Card, Coverage Bills Sail Through House

The House passed four Medicare bills Sept. 12, including measures that would create a smart card identification pilot program and codify the process for local coverage determinations of services and medical devices.

The bills also include a program that would help elderly Medicare and Medicaid beneficiaries get care in their communities, and allow some beneficiaries in Medicare Cost Plans and Medicare Advantage to switch their coverage outside the typical open enrollment period.

The House approved all four bills by voice votes. The measures represent noncontroversial health-care achievements for Congress in the run-up to the midterm elections.

Smart Cards One bill (H.R.6690) would create a smart card pilot program for Medicare to evaluate the effect on fraud of smart beneficiary identity cards. The pilot would run for three years in at least three geographic areas and would include a maximum of 2,000 health-care providers.

The Department of Health and Human Services would be required to provide cards to beneficiaries, and the hardware and software needed in the selected geographic areas at no cost.

Smart cards would have a limited effect on Medicare fraud, according to a 2015 report from the Government Accountability Office. According to the report, Centers for Medicare & Medicaid Services officials said Medicare would pay claims whether a patient used a smart card, due to concerns that forcing reliance on a smart care could limit beneficiaries' access to care.

The use of smart cards could have affected 22 percent of health-care fraud cases in 2010, but 78 percent of those cases would not have been affected by smart card use because the beneficiaries or providers were complicit in the fraud, according to a 2016 GAO analysis.

Coverage Decisions The coverage bill (H.R.3635) would codify the process by which Medicare contractors approve services and medical devices for coverage. The CMS and contractors would have to implement it by Jan. 1, 2020.

Services and medical devices are either approved on a national level by the Centers for Medicare & Medicaid Services or on a regional basis by Medicare Administrative Contractors, the private insurers that process claims.

This bill would put the process to get a local coverage determination, which is currently in a CMS manual, into statute. The bill would require Medicare to have a written public comment process, hold open public meetings, give a written rationale for the determination, and offer a reconsideration process for denied coverage.

A companion bill (S.794) was introduced in the Senate in March 2017, but no action has been taken since.

This could potentially improve guidance for doctors who are unsure of how to bill for gender reassignment surgery and other procedures without national coverage determinations.

This bill was introduced by Rep. Lynn Jenkins (R-Kan.) as a response to the CMS's proposed changes to the local coverage determination process in the calendar year 2015 physician fee schedule, Don May, with the device industry group AdvaMed, told Bloomberg Law Sept. 11. May is executive vice president for payment and health-care delivery policy at AdvaMed.

AdvaMed was concerned that the agency's proposal would have "come at the expense of transparency and stakeholder input," May said. This bill is intended to make sure the current process isn't made more difficult, he said.

This bill is meant to ensure a "means for patients, manufacturers, providers to engage with a local contractor," May said.

Community Care, Managed Care Another bill, on community care of vulnerable seniors (H.R.6561), would finalize provisions from a 2016 proposed rule. The rule would allow Medicare and Medicaid beneficiaries over the age of 55 who need nursing home-level of care to get care and services in their community under the Programs of All-Inclusive Care for the Elderly, or PACE.

The proposal "would provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice," according to the PACE rule.

A fourth bill (H.R.6662) would allow Medicare Cost Plan enrollees whose plans are ending after 2018 to switch their coverage outside the typical open enrollment period. Medicare Advantage enrollees and MA-eligible enrollees would also be able to switch their coverage.

Medicare Cost Plans are private insurance options offered in some states and will stop being offered in 2019 in areas that have at least two MA plans.

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