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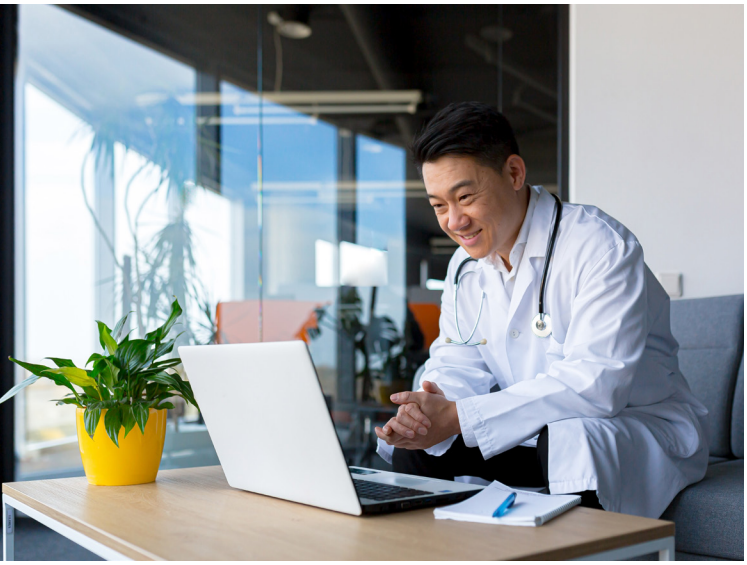

In this issue

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Telehealth

Use the OIG's data brief on telehealth to boost your compliance efforts

Check Medicare claims data, review the new program integrity measures for telehealth services and consider other telehealth-specific risks to avoid compliance issues for these services. Those are three ways health care attorneys say that practices can incorporate guidance from a recent report on telehealth services into their telehealth compliance efforts.

Practices continued to report telehealth services after states rolled back the toughest restrictions designed to slow the spread of COVID-19. The popularity of telehealth services means that practices will likely take advantage of the five-month telehealth waiver extension that was included in the Consolidated Appropriations Act of 2022 (*PBN 4/4/22*). However, the HHS Office of Inspector General's (OIG) data brief, "Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks," is a reminder that auditors are already looking at the available data (*see story, p. 3*). But that isn't the only lesson you should take from the Sept. 2 report.

Watch your billing patterns

The report reminds practices that their billing patterns are available to OIG and the public, says Sara Shanti, partner with Sheppard Mullin in Chicago. That information can be audited and compared to other practices to pinpoint potential abuse, waste or fraud, "and even used as to find potential qui tam suits," Shanti says.

In addition, practices should remember that services must meet the standards of care that are set by CMS and state law, and the documentation for each visit must prove the service

Prepare for facility E/M changes

Big CPT changes are on the way for the evaluation and management (E/M) code set in 2023, when a slew of code categories—inpatient and observation care services, nursing facility services, prolonged care codes, home visits, emergency department services, and more—will receive major code and guideline updates. Get ready during the Sept. 27 webinar **2023 CPT Changes: Prepare for Major Facility E/M Coding Updates**. Learn more: *https://codingbooks.com/YMPDA092722*.

was up to standard. In addition, there will be instances where "a virtual evaluation may not be appropriate," Shanti says.

Your practice should also think beyond the OIG report to additional compliance areas, such as prescribing activity, HIPAA compliance and steps the practice took to confirm the identity of patients who had their first visit by telehealth.

"Further, telehealth has been a platform to generate more claims, so is an area that could be overused … through unintentional poor billing hygiene," Shanti says.

The report also helps providers better understand their patients and the sort of services they want, says Amy Lerman, member of the firm with Epstein Becker Green in Washington, D.C.

"An important and general lesson that health care organizations can take from the OIG data brief is the much more significant (compared to pre-pandemic), and perhaps more realistic, look at how the Medicare population is seeking to utilize telehealth services," Lerman says. Even though telehealth proponents have long argued about the utility of telehealth, telehealth utilization remained very low prior to the PHE, she adds.

"In the data brief, OIG has considered data relating to telehealth usage by Medicare beneficiaries during the pandemic," Lerman explains. "What is most significant about this data universe is that it is so unlike anything that previously existed, and it therefore has allowed OIG to get a much more detailed look at who was using telehealth services, what services were being used, and how providers were doing with respect to billing for such services."

Make use of the 7 measures and other data

The data brief included seven program integrity measures that were custom-made for telehealth services as well as examples of behavior that could show fraud. Practices should use both as they look at their telehealth compliance, Lerman suggests.

"Together, both the examples and the identified program integrity measures are an extremely useful tool for providers," Lerman says, "as they do suggest a potential lack of sophistication on the part of providers with respect to establishing compliant coding and billing practices, and they highlight the significance of having an underlying infrastructure where regular auditing and monitoring of claims for these services is being done consistently and thoughtfully," she says.

Lerman predicts the information will be extremely useful for practices that want to reduce their compliance risks. For example, the information on average and extreme providers will be helpful "to train providers and staff, as a means of enforcing good and compliant behaviors," Lerman says. "OIG seems to be suggesting just as much in its recommendations — increased monitoring and oversight of telehealth services, educating providers on appropriate billing practices for telehealth services, and improving the reporting of the types of providers and the organizations that are delivering the telehealth services."

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Richard Scott, 267-758-2404
Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Julia Kyles, CPC, x6015
Editor
jkyles@decisionhealth.com

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Dig into CMS' data for your providers

CMS has published several years of claims data that are linked to the billing provider's name, address and other attributes. It is available on CMS' Data.gov site under the "Medicare Physician & Other Practitioners" tab. Practices should use it to review their Medicare claims data and to understand how they look to the world at large, Shanti says.

Practices should be aware that this information isn't confidential. "If the public can see it, then competitors can see it, people who might bring a qui tam case can see it, and enforcement can take advantage of it," Shanti says.

And if the idea of data mining for each provider at your practice is too daunting, there are third-party companies that will extract the data, put it in order and help the practice put it to use, Shanti says.

Don't panic if you're above the norm

The report contains data for extreme and average billing, but practices that are above average should not assume they've done anything wrong. Telehealth services were new to most providers in 2020, Lerman says, and practices adopted them during a chaotic time.

"While mistakes with respect to billing and coding are never entirely avoidable, if a health care organization is properly equipped to identify and correct mistakes when they happen, as well as to continuously train its providers and other staff to minimize occurrence of such mistakes in the first place, they will have the appropriate operational checks and balances to help ensure ongoing, compliant behavior," Lerman says.

Some practices will be above average because of their specialty or other factors. But being high for a season or a year isn't the same as being in the 90th percentile for 10 years, Shanti says. In fact, underbilling could be more common than overbilling.

"It's really interesting; we've seen that," Shanti says. "It's amazing how many you see that are way under the norm." Reasons for underbilling include practices with conservative billing habits, automated billing or not understanding the rules. "I think it is important for those who are being conservative to know they may be missing out on revenue," Shanti adds. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- HHS Office of Inspector General data brief - Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks: *https://oig.hhs.gov/oei/reports/OEI-02-20-00720.asp*
- CMS provider-specific claims data - Medicare Physician & Other Practitioners: *https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners*

Telehealth

OIG to CMS and legislators: Build program integrity into any new telehealth rules

While legislators and policy creators debate permanent changes to Medicare's telehealth rules, the HHS Office of Inspector General (OIG) issued a call to build program integrity protections into any changes. The agency included the reminder in its Sept. 2 data brief, "Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks."

"As permanent changes to telehealth are considered, it is essential that CMS, Congress, and other stakeholders incorporate targeted, appropriate safeguards to prevent, detect and remediate the program integrity risks identified in this report," the OIG states.

The OIG used Medicare data and input from investigators to create seven program integrity measures that "focus on different types of billing that providers may use to inappropriately bill for telehealth services." The agency also created thresholds for each measure that "may indicate possible fraud, waste or abuse" and provided information about normal billing patterns. The OIG found that aberrant telehealth claims tended to have the following characteristics:

1. Billing a telehealth service and a facility fee for at least 75% of visits. According to the OIG, "most providers never billed this way."
2. Billing the highest level for office, nursing home, residential and home telehealth visit. Most providers "rarely, if ever" billed the highest-level visit for a telehealth service in these settings, the OIG said.
3. Billing telehealth services for more than 300 days in a year, which works out to an average of 25 days a month. The median for the review period was 26 days in a year.

4. Billing both Medicare fee-for-service and a Medicare Advantage plan for the same service for more than 20% of services. Most providers never billed this way, according to the OIG.
5. Billing telehealth visits that averaged more than two hours per visit, compared to the median time of 21 minutes.
6. Billing telehealth services for more than 2,000 beneficiaries. The median was 21 beneficiaries.
7. Billing for a telehealth service and ordering medical equipment for at least 50% of their patients, compared to a median of 3%.

The OIG reviewed claims submitted by 741,759 doctors and qualified health care professionals and identified 1,714 providers whose billing exceeded the OIG's thresholds for at least one measure. The OIG deemed those providers' billing "posed a high risk to Medicare." The data brief reviewed telehealth services from March 1, 2020, to Feb. 28, 2021.

While the agency reviewed only a small amount of providers performing telehealth services, the low number of problematic providers may not reflect the extent of the problem. The agency deliberately set a high bar for its thresholds and noted that the providers identified by the review represented extreme cases. Four examples from the report illustrate just how far from the norm some providers strayed:

1. Two family practice providers billed nearly 18,600 services for slightly more than 1,800 beneficiaries, an average of more than 10 services per patient.
2. A provider associated with a telehealth company billed for more than 27,400 patients. That would be an average of 75 patients a day every day of the year.
3. Ten providers billed an average of at least three hours, which is eight times longer than the average visit.
4. One provider billed the highest level for their telehealth home visits and billed prolonged services for more than 50% of the services.

The review did "not capture all concerning billing related to telehealth services that may be occurring in Medicare," the OIG said. One area it couldn't track was the extent of incident-to billing, which "creates challenges for oversight because it allows services provided by clinical staff who are directly supervised by a practitioner to be billed under the supervising practitioner's identification number," the OIG said.

OIG's recommendations to CMS included creating a way to track incident-to services. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCE

- Medicare telehealth services during the first year of the pandemic: Program integrity risks: *https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf*

Health IT

Physicians eager to tap into tech explosion, remote monitoring poised to surge

A new study from the AMA shows physicians growing ever more comfortable with multiple forms of health care technology. The growth of telehealth is expected, but some tools that are also gaining fast, such as remote patient monitoring (RPM), may be less expected. Perhaps the biggest growth stock of all, though, is in the non-clinical area of price transparency and related data tools.

In September, the AMA issued its Digital Health Research report, subtitled "Physicians' Motivations and Key Requirements for Adopting Digital Health Adoption and attitudinal shifts from 2016 to 2022." It follows up on 2016 and 2019 reports that tracked attitudes toward, and the progress of, these digital tools in medical practice.

In the survey of 1,400 physicians from various practice types and specialties, the AMA found physician use of technology tools in seven categories growing over the six-year period: Remote patient monitoring (RPM) for efficiency; remote monitoring and management for improved care; apps and devices for use by chronic disease patients; clinical decision support; patient engagement; tele-visits/virtual visits; point of care/workflow enhancement; communication and sharing of electronic clinical data; and consumer access to clinical data.

Telehealth was the big gainer, which is a direct result of the pandemic; the AMA's previous report showed the percentage of physicians using it doubling between 2016

(continued on p. 6)

Benchmark of the week

5 specialties led the charge for adopting remote physiologic monitoring

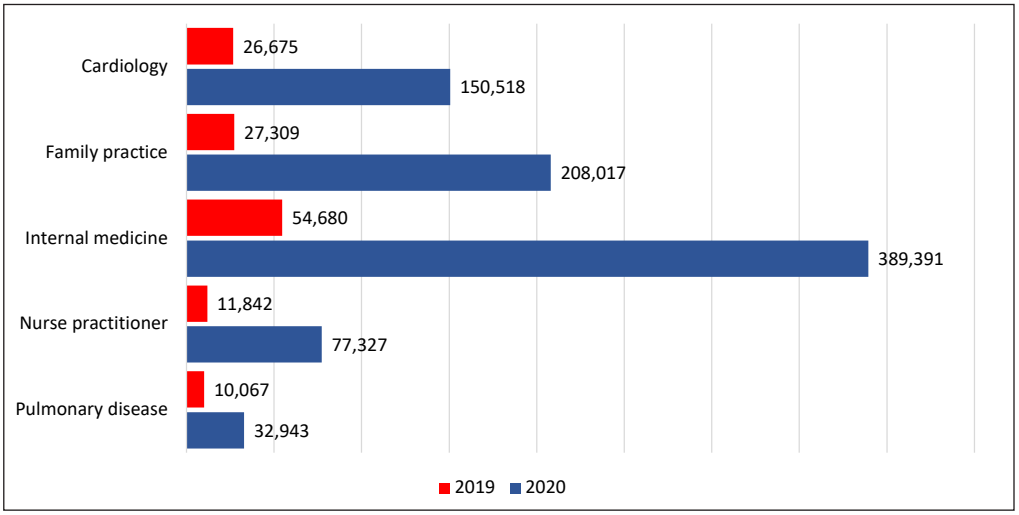
Five specialties added new E/M remote physiologic monitoring (RPM) services to their practices in 2019 and continued to increase reporting in 2020. Internal medicine was at the head of the pack in 2019 and stayed there in 2020, according to a review of Medicare Part B data for 2019 and 2020, the latest available.

As part of this analysis, *Part B News* analyzed every specialty based on their claims for E/M RPM services in 2019 and 2020 and winnowed the results down to the top five specialties. (*See chart, p. 6, for the series of codes involved in the analysis*). The results revealed that RPM services were extremely popular with primary care providers — the family practice, internal medicine and nurse practitioner specialties. Cardiology and pulmonary disease made up the remaining top reporters. The top five specialties stayed consistent across both years.

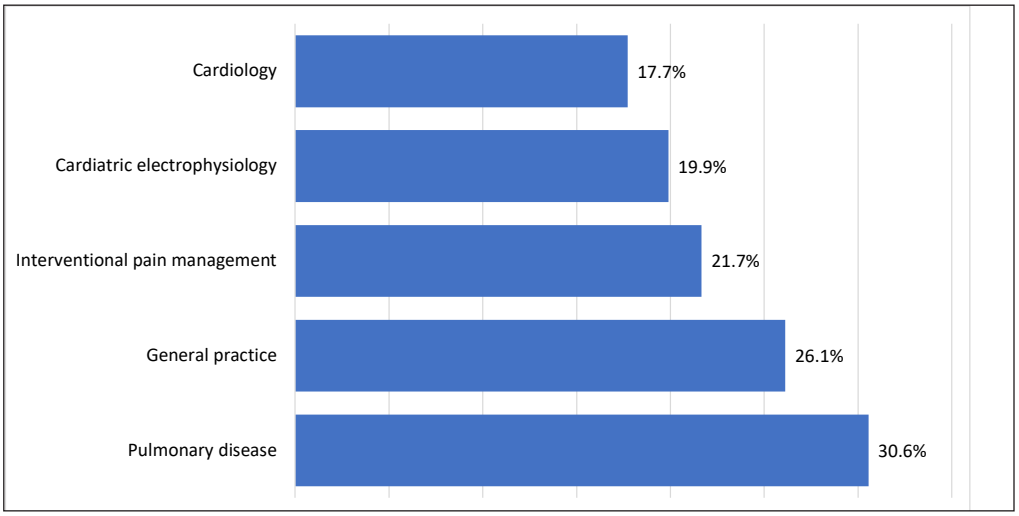
The "RPM utilization increase" chart began with an analysis of the top 10 specialties for 2020 and a calculation of the percentage change for the RPM claims they submitted from 2019 to 2020. The chart shows the five specialties with the highest percentage changes. Three of the specialties — cardiac electrophysiology, general practice and interventional pain management — were not top reporters for either year but showed steep increases in reporting in the two-year period.

Sticking with RPM in 2020 was no mean feat. Practices incorporated a revision to one code and the creation of three new codes while still learning to bill the codes introduced or revised in 2019. In addition to RPM-related challenges, practices also had to adjust to the COVID-19 public health emergency (PHE). — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

Total RPM claims by top 5 specialties 2019-2020



RPM utilization increase for top 5 specialties, 2019-2020



Source: Part B News *analysis of 2019-2020 Medicare claims data*

(continued from p. 4)

and 2019 to 28%, but now 80% of them do. Physician "enthusiasm" for telehealth grew from 36% to 57%.

Usage in other categories climbed at slower rates. And while physician enthusiasm also grew in other categories, it was flat for clinical decision support and ticked slightly down for point of care/workflow enhancement, patient engagement, and consumer access.

Nonetheless, AMA President Jack Resneck, Jr., M.D., finds the general upward trend encouraging.

"Even on some of the technologies where the numbers were not as high as telehealth — where we just saw a massive increase in adoption with the pandemic and with new coverage — the [overall] growth was still impressive," Resneck says. "[It's also impressive] when you see something like remote monitoring [for improved care] use going from 13% to 34%, and when you see not just large health systems but also small and mid-sized practices having some of the biggest increases in their use of digital health."

RPM set to grow

Remote patient monitoring — distinguished in the survey between RPM that records simple readings, such as blood pressure, and RPM that connects providers with "chronic disease patients for daily measurement of vital signs" — is an enigmatic case. Though use is up and a substantial 53% of physicians are "enthusiastic" about it, at 30% and 34% it's still the least-used of the seven categories. However, nearly two in five physicians say they will adopt it in the next year.

Paul Brient, chief product officer of athenahealth, thinks RPM is going "to grow and will become standard of care," driven in part by the increase in patients with chronic disease. "Specialized devices to monitor blood sugar or blood pressure or weight are already available and can be game-changing in terms of ensuring that patients with chronic conditions are managing those conditions as effectively as possible and to intervene when needed, not when scheduled," Brient says.

"Virtual care management, including remote physiological and therapeutic monitoring, has matured significantly in just the past four years," says Rebecca Gwilt, co-founder of the Nixon Gwilt law firm in Washington, D.C. To Gwilt, the AMA's data "confirm what we've been observing as well … The fee-for-service codes for remote monitoring are as new as 2018, so the non-institutional market for them is still in its nascency. And yet we're already at the point where the platforms are EHR-integrated and contain detailed dashboards and customized alerts that help clinicians and their clinical staff monitor hundreds of patients at once."

Gwilt expects to see this evolve to encompass "remote therapeutic monitoring — that is, monitoring for the kinds of ailments that can't be neatly captured in

Coding

A brief history of remote physiologic monitoring, 2019-2020

You need a scorecard to keep track of coding and coverage changes for remote physiologic monitoring (RPM) services in the E/M chapter of the CPT manual. In 2019 and 2020, practices that reported RPM services adjusted to several new and revised codes (*see benchmark, p. 5*). The following chart provides a brief history of changes for codes that were in effect during those years. – *Julia Kyles, CPC* (jkyles@decisionhealth.com)

Code and consumer friendly descriptor	History
99091 (Collection and interpretation of physical parameters stored in computers and/or transmitted by the patient and/or caregiver to qualified health care professional, requiring 30 minutes or more, per 30 days)	Created in 2002, covered 2018. Revised in 2019.
99453 (Remote monitoring of physiologic parameters, initial set-up and patient education on use of equipment)	New in 2019, covered in 2019.
99454 (… ; initial supply of devices with daily recordings or programmed alerts transmission, each 30 days)	New in 2019, covered in 2019.
99457 (Management using the results of remote vital sign monitoring per calendar month, first 20 minutes)	New in 2019, covered in 2019. Revised in 2020 to be a primary code.
99458 (… ; each additional 20 minutes)	New in 2020 as an add-on code for 99457, covered in 2020.
99473 (Education and training to self measure blood pressure)	New in 2020, covered in 2020.
99474 (Self measured blood pressure measurements)	New in 2020, covered in 2020.

Bluetooth-enabled devices like scales and blood pressure cuffs," such as self-reported pain and mental health status.

Over time, Brient sees these clinical-grade RPM devices and the sub-clinical-grade wearables like Apple watches and FitBits "coming together, with the necessary AI, to enable your providers to engage virtually with you constantly and intervene when it is most helpful."

One big issue remains privacy. By and large, Resneck says, consumer health apps aren't covered by HIPAA, and under current regulations medical information sent to them from EHRs may be misused by third parties (*PBN 3/22/21*). It may be that as the technology evolves, so will standards that protect that data.

Front end tech emerges, too

While technology to treat patients remains foremost in physicians' regard, there are also plenty of innovations in the administration of medicine, spurred by new medical models, regulations related to transparency, and the seemingly limitless reach of algorithms and information science.

Inference Health, for example, was born out of the bundled-care revolution that started with CMS demonstration models and has evolved to encompass other insurers and even private companies (*PBN 5/13/19*). The company uses information technology to design packages to meet patient, provider and payer requirements.

"Bundling has traditionally focused on very sophisticated health care players such as Kaiser that can negotiate with CMS or United Healthcare, for example, because these packages can be really complex," says Daniel Wu, founder and CEO of Inference. But thanks to advances that make it possible to run complex cost numbers on demand, as well as "laws and regulations that say anyone with an NPI has to disclose in all their prices and costs in machine readable files … bundling can work for smaller practices," Wu says. "We primarily work with ambulatory surgical centers and orthopedic surgeons."

Another health IT company, Arrive Health, works with the data held by payers to make them actionable by providers and in electronic health records (EHR), explains Adam Rosenberg, Arrive's senior director of marketing. He points to the panoply of recent federal regulation related to price transparency that require this kind of sophisticated data handling, including the "beneficiary real time benefit tool" that CMS is requiring Part D plans to provide starting in 2023.

"Complexity in health care data has become unmanageable," Rosenberg says. "Every patient could be on a different plan and every plan could have a variety of factors that would make it literally impossible for a provider to understand what is covered for every patient ... the opportunity for solution providers like Arrive Health is huge because that complexity is only going to get worse."

Beware untried tech

In the current wild-west medical technology environment, some products and services, even those cleared by the FDA, may come onto the market with bugs. One reason the AMA keeps close tabs on this technology, Resneck says, is to assure physicians that as the medical technology advances, both patients and physicians get products and services that work the way they're supposed to.

Resneck notes some cautionary tales. For example, he cites Optum's Impact Pro risk prediction program for chronic care, which drew criticism in 2018 because "it used a health care expenditures as a proxy for health care needs," Resneck says, which ended up short-changing Black chronic care patients because they tended to spend less money on care for reasons unrelated to care needs. On the clinical side, Resneck cites an investigation by *JAMA Dermatology* of a convolutional neural network (CNN) used by dermatologists that had been inadvertently trained to read a physician's clinical markings as evidence of melanoma, meaning it overdiagnosed images in which the clinician had marked a mole for other purposes.

But Resneck is confident the industry can work out those kinks and continue to improve the health care experience.

"We spend a lot of our time talking about the concerns, but it's important to note that physicians are really enthusiastic about adopting these technologies,"

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Resneck says. "In the midst of this pandemic, digital health has really been a bright spot." — *Roy Edroso* (*redroso@decisionheath.com*) ■

RESOURCE

- AMA 2022 Digital Health Research: *www.ama-assn.org/system/files/ama-digital-health-study.pdf*

Physician payments

Congress debating path to flatten expected provider payment cuts

Heads up: Congress is working up a bill to relieve providers whose reimbursement is set to take a sharp cut in 2023. But lawmakers seem inclined to take a different path than they did last year.

Cuts in provider reimbursement that CMS announced in July in the proposed Medicare physician fee schedule (PFS) raised an outcry among practices. CMS is threatening to drop the 2023 conversion factor from $34.61 to $33.08, or 4.4% (*PBN 7/18/22*). A similar cut was in store last year, when Congress rode to the rescue with a package of cuts that included a delay of the 2% sequestration cut to April 2022, at which time it was held to 1% (until July, when the other 1% was put back on), and pushed the 4% PAYGO cut slated for 2022 to 2023; they also quashed most of the then-planned PFS conversion factor cut of 3.75% (*PBN blog 12/10/21*).

That 2021 law was called the Supporting Medicare Providers Act, the same name as the one before the House of Representatives now, but this year's version is arranged differently. For one thing, it doesn't address the sequester at all, which means that on Jan. 1, 2023, you'll still get a 2% bite.

And PAYGO is untouched, so that extra 4% cut is still on the books as well, though Congress has found ways to avoid it in the past. Claire Ernst, director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C., hears that's their plan this year, too, possibly in separate legislation.

The current bill, if passed in its current form, would flatten out the 4.4% PFS conversion factor cut with a 4.42% pay boost.

Also, there's still a chance that CMS will give you a little more of a break in the PFS final rule, says Suzanne M. Joy, senior public affairs advisor for Holland & Knight LLP in Washington, D.C. "CMS could reverse some of the coding changes proposed in this year's rule, which cumulatively account for around 1.5% of the total 4.42% reduction to the conversion factor," Joy says. That would more or less cancel out a 1.5% budget neutrality cut that's also due in 2023.

But anything else would require congressional action, Joy says.

'Doc fix' redux causes reflux

Joy, Ernst and others agree that the repeating Supporting Medicare Providers Act legislation at year's end is uncomfortably reminiscent of the "doc fix" Congress used to reliably push through every December to stave off double-digit sustainable growth rate (SGR) cuts, until the Medicare Access and CHIP Reauthorization Act of 2015 did away with it (*PBN 4/20/15*).

"I think everyone is feeling the heartburn associated with that," Ernst says. But she also says there are plans afoot to head off Doc Fix II. For one thing, U.S. Representatives Ami Bera, M.D., (D-Calif.) and Larry Bucshon, M.D., (R-Ind.), among others, have a request for information out for "actions Congress should take to stabilize the Medicare payment system, without dramatic increases in Medicare spending, while ensuring successful value-based care incentives are in place." Their RFI mentions MACRA's Quality Payment Program and the expected disappearance of many performance incentives that might have lessened the impact of pay cuts.

Joy has heard talk of an inflation-based PFS update. "Notably, other Medicare fee schedules, like the outpatient rule, already have something along those lines," she says. And a budget neutrality waiver could also come into play. "The main hurdle there is the cost, which would likely be fairly significant," she says. "I'd imagine Congress will also want it to see it replaced with some other type of Medicare spending control mechanism."

Stay tuned to further updates. The final PFS is due out in early November, and lawmakers would likely act before the end of the calendar year if they were to address any cuts. — *Roy Edroso* (*redroso@decisionheath.com*) ■

RESOURCES

- "Supporting Medicare Providers Act of 2022," text: *www.congress.gov/bill/117th-congress/house-bill/8800/text?r=1&s=1*
- Press release, "Bera and Bucshon Lead Group of Representatives in Seeking Input on Medicare Payment System": *https://bera.house.gov/media-center/press-releases/bera-and-bucshon-lead-group-representatives-seeking-input-medicare*