

12/10/2013 09:59

Description of the Chairman's Mark

**The SGR Repeal and Medicare Beneficiary
Access Improvement Act of 2013**

Scheduled for Markup
By the Senate Committee on Finance
On December 12, 2013

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Title I—Medicare Payment for Physicians’ Services

Sec. 102. Short title; Table of Contents.

Current Law

No provision.

Chairman’s Mark

This act would be cited as the, “SGR Repeal and Medicare Beneficiary Access Act of 2013.” Unless otherwise noted “Secretary” would refer to the Secretary of Health and Human Services (HHS).

Sec. 102. Repealing the Sustainable Growth Rate and Improving Medicare Payment for Physicians’ Services.

Current Law

Medicare payments for items and services furnished by physicians and other professionals are made on the basis of a fee schedule. The fee schedule assigns relative values to each of the approximately 7,500 service codes that reflect professional work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians’ services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS). The relative values are adjusted for geographic variation in input costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The Centers for Medicare & Medicaid Services (CMS), which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has historically provided advice and recommendations to CMS to assist in the assessments. CMS is required to review the RVUs at least every five years.

In determining adjustments to RVUs used as the basis for calculating Medicare professional reimbursement under the physician fee schedule, the Secretary has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required publish an explanation of the basis for such adjustments. These adjustments are subject to a budget neutrality condition. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the Medicare physician fee schedule to

differ from year to year by more than \$20,000,000 from the expenditures that would have been incurred without such an adjustment.

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) requires that, in developing the resource based practice expense RVUs, the Secretary (1) use generally accepted cost accounting principles, to the maximum extent possible, that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization, (2) develop a refinement method to be used during the transition, and (3) consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician practice expense.

An additional provision of the BBA was the Sustainable Growth Rate (SGR), a statutory method for determining the annual updates to the Medicare physician fee schedule. The SGR methodology was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services.

Generally, under the SGR formula, comparisons of actual versus target spending for both the current year as well as cumulatively (going back to 1996, the base year) will determine the magnitude and direction (positive or negative) of the update adjustment factor. For example, if current year comparisons as well as cumulative expenditures from the current period going back to 1996 are less than the cumulative spending target over the same period, the annual update is increased according to a statutory formula. If, however, spending exceeds the cumulative spending target over the same period, the SGR methodology necessitates fee schedule update reductions to bring spending back in line with the target growth rate.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). Beginning in 2002, the cumulative actual expenditures exceeded allowed targets, resulting in SGR-mandated reductions in the update adjustment factor and the discrepancy has grown with each year. With the exception of 2002, when a 4.8 percent decrease was applied, Congress has enacted a series of laws to override the reductions.

Most recently, the American Taxpayer Relief Act 2012 (ATRA, P.L. 112-240) included a provision that averted the reduction and maintained the Medicare physician fee schedule payments at current rates through December 31, 2013. The Congressional Budget Office (CBO) estimates that, without additional Congressional intervention, the statutory change in the update factor would result in a 23.7 percent reduction in payment rates under the Medicare physician fee schedule.

Over time, Congress has added provisions to the physician fee schedule that are intended to improve the quality of care delivered to Medicare beneficiaries and constrain the growth of Medicare spending for professional services. The Tax Relief and Health Care

Act of 2006 (TRHCA, P.L. 109-432) required the establishment of a physician quality reporting system (PQRS) that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures, based on a percentage of the allowed Medicare charges for all such covered professional services. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent of total allowable charges under the physician fee schedule in 2007 and 2008 to two percent in 2009 and 2010.

The Affordable Care Act (ACA, P.L. 111-148) extended the PQRS incentive payments through 2014 and put in place a penalty for providers who do not report quality measures beginning in 2015. Eligible professionals who successfully report in 2010 are to receive a one percent bonus in 2011; those who successfully report in 2011, 2012, and 2013 will receive a 0.5 percent bonus in 2012, 2013, and 2014, respectively. By contrast, eligible professionals who fail to participate successfully in the program would face a 1.5 percent payment penalty in 2015, and a two percent payment penalty in 2016 and in subsequent years. The incentive payments and adjustments in payment will be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percentage of the fee schedule amount.

Both the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns in response. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. To that end, section 131 of the Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) established a physician feedback program. The physician feedback program uses Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. CMS initially called this effort the Physician Resource Use Feedback Program, but has renamed this initiative the “Physician Resource Use Measurement and Reporting Program.”

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) authorized incentive payments over a five-year period through Medicare Part B to physicians who are meaningful users of certified electronic health record (EHR) technology. Meaningful use is defined as (1) demonstrating to the satisfaction of the Secretary the use of certified EHR technology in a meaningful manner (including e-prescribing), including for the purpose of exchanging electronic health information to improve health care quality; and (2) using such certified EHR technology to report clinical quality measures, as selected by the Secretary. The incentive payments equal 75 percent of the allowed Part B charges during the reporting year. The total amount that a physician could receive is capped and decreases over time. Beginning in 2011, eligible physicians received up to \$15,000 in the first payment year, \$12,000 in the second year, \$8,000 in the third year, \$4,000 in the

fourth year, and \$2,000 in the fifth, and final, year. Early EHR adopters whose first payment year was 2011 or 2012 received up to \$18,000 (instead of \$15,000) for that year.

Eligible physicians who become meaningful EHR users for the first time after 2013 will receive fewer payments and those who do not adopt EHRs until after 2014 will receive no bonus. For eligible physicians practicing in health professional shortage areas, the incentive payment amounts are increased by 10 percent. No incentive payments will be made after 2016. Incentive payments are not available for hospital-based physicians. Eligible physicians who are not meaningful EHR users by 2015 will see their Medicare payments reduced by the following amounts: one percent in 2015, two percent in 2016, three percent in 2017 and in each subsequent year. For 2018 and each subsequent year, if the proportion of eligible physicians who are meaningful EHR users is less than 75 percent, the payment reduction will be further decreased by one percentage point from the applicable amount in the previous year, though the reduction cannot exceed five percent. The Secretary may, on a case-by-case basis, exempt eligible physicians (e.g., rural physicians that lack sufficient Internet access) from the payment reduction for up to five years if it is determined that being a meaningful EHR user would result in significant hardship.

Physician fee schedule payments, which are made on a fee-for-service basis, have been criticized for rewarding volume of care without incentivizing quality or improved outcomes. While payments made under the physician fee schedule are modified based on geography and to achieve specific policy objectives (i.e., when providing an incentive for physicians to provide care in underserved areas), historically, the physician fee schedule has not varied payments with respect to quality or efficiency.

The ACA required the Secretary to establish a value-based payment modifier, a separate, budget-neutral payment modifier that adjusts payments under the Medicare physician fee schedule based on the relative quality and cost of the care provided. Quality of care is to be evaluated on a composite of risk-adjusted measures of quality established by the Secretary, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, are to be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and the health status of individuals) and other factors determined appropriate by the Secretary.

Beginning January 1, 2015, the value-based payment modifier will apply for items and services furnished for physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number (TIN) based on performance in CY2013. By 2017, the value-based payment modifier will apply to all physicians who participate in fee-for-service Medicare. The Secretary is to apply the payment modifier in a manner that promotes systems-based care and takes into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

Chairman's Mark

The Chairman's Mark would repeal the SGR methodology for determining updates to the Medicare physician fee schedule. It would: (1) provide a 10-year period of stable fee updates (at 0 percent per year); (2) establish a value-based performance program that consolidates and enhances several existing incentive programs; (3) incentivize the development of, and participation in, alternative payment models (APMs); and (4) make other changes to Medicare physician payment policies.

The update to the conversion factor for the Medicare physician fee schedule would be zero percent for each year from 2014 through 2023. Beginning in 2024 and in subsequent years, the update would vary, depending on whether the provider is a participant in a qualifying APM. For services furnished by a qualifying APM participant, the update would be 2 percent, while the update for all other services would be 1 percent.

By July 1, 2016, MedPAC would be required to submit a report to Congress on the relationship between (1) physician and other health professional utilization and expenditures, and the rate of increase of such utilization and expenditures of items and services paid for under Part B of the Medicare program, and (2) total utilization and expenditures and their rates of increase under Medicare Parts A, B, and D. The report would include a methodology to describe this relationship and the impact of changes in practice and service ordering patterns of physician and other health professionals on total utilization and expenditures, of health care services in Medicare Parts A, B, and D. A final report, applying the methodology developed, would be due to Congress by July 1, 2020.

The Chairman's Mark would create a new incentive payment system, which would be called the value-based performance incentive program (VBP program). This program would extend key components of three existing programs and would sunset their payment incentives and separate application by consolidating and incorporating them into the new VBP program beginning on January 1, 2017 (the payment incentives for these programs would continue to be in effect for CY2015 and CY2016). These three programs are: (1) the Medicare EHR incentive program for meaningful use of certified EHR technology, (2) the quality reporting incentive program (currently called the Physician Quality Reporting System (PQRS)), and (3) the value-based payment modifier. The VBP would continue to use the provisions and processes of these programs including meaningful use determinations already carried out by the Medicare program, PQRS quality metrics already being reported by professionals, and requirements for quality and resource use measurement under the value-based payment modifier. Adjustments in the application of these provisions would be made to ensure consistency with the new VBP program so that duplicative requirements do not apply.

The VBP program would accomplish the following:

1. develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards described below for a performance period for a year;

2. using the methodology above, provide for a composite performance score (defined below) for each eligible professional for each performance period; and
3. use the composite performance score of the VBP eligible professional for a performance period for a year to make VBP program incentive payments (as described below) to the eligible professional for the year.

The VBP program would apply to payments for items and services furnished on or after January 1, 2017.

The types of health care professionals eligible for the VBP incentive payments would expand over time. Subject to the exclusions described below, physicians (as defined under section 1861(r)(1) of the Social Security Act (SSA)), physician assistants, nurse practitioners, and clinical nurse specialists (defined under section 1861(aa)(5) of the SSA), and certified clinical nurse specialists (defined under section 1861(bb)(2) of the SSA), and certified registered nurse anesthetists (defined under section 1861(bb)(2) of the SSA) would be eligible for the VBP program in 2017 and 2018. The Secretary would decide which eligible professionals described under section 1848(k)(3)(B) of the SSA, in addition to those already specified, could be eligible for the VBP program in 2019 and subsequent years.

Health care professionals excluded from the VBP program would include otherwise eligible professionals who (1) would be qualifying APM participants (as defined below), (2) would be partial qualifying APM participants (as defined below) who do not report on the applicable measures and activities (partial qualifying APM participants, who chose to report under the VBP program despite this exclusion, would be eligible for VBP incentive payments) and (3) would not exceed the low-volume threshold measurement.

The Secretary would select one of the following low-volume threshold measurements to determine the above exclusion for the performance period:

1. a minimum number of Medicare beneficiaries who are treated by the eligible professional,
2. a minimum number of items and services furnished by the professional to Medicare beneficiaries, or
3. a minimum amount of Medicare allowed charges billed by the professional.

In each case, the minimum number would be determined by the Secretary. A new VBP-eligible professional who had not previously submitted Medicare claims as a person, an entity, or as a part of a physician group or under a different billing number or tax identifier, would be eligible for the VBP incentive program beginning in the subsequent year and performance period for such year.

Payments to professionals who are not VBP eligible professionals would not be affected by any reduction in payments for establishment of the funding pool for VBP incentive payments or by any VBP program incentive payments.

The Secretary would encourage the use of qualified clinical data registries (as specified in current law) in carrying out this program.

The VBP program would use measures and activities under four performance categories. A composite performance score would be calculated for each VBP eligible professional, which would be used to determine the VBP program incentive payment amounts. The Secretary would use the following performance categories to determine the composite performance score and the measures and activities specified for each category:

1. Quality - The quality performance category would use quality measures established under current law for the PQRS program (sections 1848(k) and 1848(m) of the SSA) and the value-based payment modifier (section 1848(p)(2) of the SSA). The Secretary would, as feasible, emphasize the application of outcome measures, and could use measures used for a payment system other than for physicians or use global measures, such as global outcome measures, and population-based measures. Analysis of measures used under the quality performance category could include data submitted by VBP eligible professionals from multiple payers.
2. Resource use - The resource use performance category would use measures of resource use established under current law for the value-based payment modifier (section 1848(p)(3) of the Social Security Act). To the extent feasible, resource use measures would account for the cost of Part D drugs. As appropriate, the Secretary would employ resource use measurements developed through the process for collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement described below.
3. Clinical practice improvement activities - The clinical practice improvement activities performance category would use activities specified by the Secretary, including at least the following subcategories:
 - a) expanded practice access, which would include activities such as same-day appointments for urgent needs and after-hours access to clinician advice;
 - b) population management, which would include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry;
 - c) care coordination, which would include activities such as timely communication of test results, timely exchange of clinical information,

and use of remote monitoring or telehealth;

- d) beneficiary engagement, which would include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms;
- e) patient safety and practice assessment, which would include activities such as the use of clinical or surgical checklists and practice assessments related to maintaining certification; and
- f) participation in an alternative payment model, as defined below.

In establishing the clinical practice improvement activities, the Secretary would give consideration to the circumstances of small practices and practices located in rural areas and in health professional shortage areas (as described in section 332 (a)(1)(A) of the Public Health Service Act). The Secretary could contract with entities to assist in (1) identifying the activities, (2) specifying criteria for such activities, and (3) determining whether a VBP eligible professional meets such criteria. Additionally, the Secretary would use a request for information process to solicit recommendations from stakeholders for identifying other activities not expressly listed above, and specifying criteria for such activities.

4. Meaningful use of certified EHR technology - The Meaningful EHR use performance category would use requirements established for purposes of section 1848(o) of the SSA for such period for determining whether an eligible professional is a meaningful EHR user for such period.

The Secretary would establish performance standards with respect to measures and activities under each of the four VBP performance categories for the performance period for a year. The performance standards would take into account (1) historical performance standards, (2) improvement rates, and (3) the opportunity for continued improvement.

The Secretary would establish a performance period (or periods) for each year in which incentive payments would be made under the VBP program, beginning with 2017; the performance period would begin and end prior to the beginning of the year in which the incentive payments would be paid and be as close as possible to the payment year.

With respect to assessing performance in the quality performance category, the Secretary would be required to establish and apply a process for applying the VBP program to group practices, which would include features of provisions that currently apply to group practices in the Physician Quality Reporting System. With respect to assessing performance of group practices in the remaining three performance categories described above, the Secretary could also apply such a process for groups.

In determining these processes, the Secretary would reflect the full range of items and services furnished by the VBP eligible professionals in the group practice involved, to the extent practicable. VBP eligible professionals electing to be a virtual group (as described below) would not be considered VBP eligible professionals in a group practice.

The Secretary would develop a methodology for assessing the total performance of each VBP eligible professional according to the performance standards and the applicable measures and activities specified above with respect to each performance category applicable to an eligible professional for a performance period. Using the methodology developed, the Secretary would determine a composite assessment (‘composite performance score’) for each such professional for each performance period.

In weighting the performance categories, measures, and activities to determine the composite performance score, the Secretary may assign different scoring weights (including a weight of 0) for (1) each performance category based on the extent to which the category is applicable to the type of eligible professional involved, and (2) each measure and activity based on the extent to which the measure or activity is applicable to the type of eligible professional involved. With respect to the quality performance category, the Secretary would assign a higher scoring weight to outcomes measures than to other measures and increase the scoring weight for outcome measures over time. The Secretary could also assign a higher scoring weight to patient experience measures.

To incentivize reporting of activities and measures used to determine the composite performance score, a VBP eligible professional who failed to report on an applicable measure or activity that is required for such professional would be treated as having achieved the lowest potential score applicable. To encourage the use of certified EHR technology for reporting quality measures, the Secretary would (1) encourage VBP eligible professionals to report on applicable quality measures through the use of certified EHR technology, and (2) treat any VBP eligible professional who reports the applicable quality measures through the use of such EHR technology as having satisfied the clinical quality measures reporting requirement to be a meaningful EHR user under section 1848(o)(2)(A)(iii) of the SSA.

For the performance category of clinical practice improvement activities, a VBP eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice – by an organization that is recognized by the Secretary for purposes of certifying medical homes and specialty practices – would be given the highest potential score for the clinical practice improvement activities performance subcategory. A VBP eligible professional in an alternative payment model, as defined below, would earn one-half of the highest potential score for the clinical practice improvement activity performance category. Such professional could also earn more than one-half of the highest potential score for this performance period by performing additional activities with respect to the same performance category. A VBP eligible professional would not be required to perform activities in each subcategory of the clinical practice improvement activity performance category to achieve the highest potential score for this performance category.

The Secretary would ensure that the application of the methodology developed to determine the composite performance score would result in a continuous distribution of performance scores, which would subsequently result in differential incentive payments for VBP eligible professionals.

Beginning with the second year of the VBP program, in addition to the achievement score of a VBP eligible professional, the composite score methodology (1) would take into account improvement in the quality performance and the resource use performance categories, and (2) could take into account improvement in the other performance categories. Beginning with the fourth year of the VBP program, the composite score methodology would assign a higher scoring weight with respect to the achievement score than to any improvement score with respect to a measure or activity, or a performance category or both.

In general, subject to the adjustment noted below, the composite performance score would be determined based on the following weights: quality (30 percent), resource use (30 percent), clinical practice improvement activities (15 percent), and meaningful use of EHR technology (25 percent). In any year in which the Secretary estimates that the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater, the Secretary could reduce the percent applicable from 25 percent, but not below 15 percent. If the Secretary were to make such a reduction, the weights of the other categories would be increased such that the total percentage points of the increase would equal the total number of percentage points by which the EHR category were to be reduced.

The weights for the quality and resource use performance categories would always be equal, even after the application of the above EHR adjustment, with the following exception. For the first two years of the VBP program, after any EHR adjustment, the Secretary could increase the weight for either the quality or the resource use performance category, as long as the Secretary were to decrease the weight under the other category by an equal number of percentage points and so long as neither weight is less than 15 percent.

The Secretary would provide a process to allow an individual VBP eligible professional or a group practice consisting of not more than ten VBP eligible professionals to elect to be a virtual group with at least one other individual VBP eligible professional or group of VBP eligible professionals. For VBP eligible professionals who elect to be a virtual group, (1) the assessment on the quality and resource use performance categories applied to each professional in such group would be with respect to the combined performance of all such professionals in such group, and (2) the composite score under the VBP program for each VBP eligible professional in the virtual group would be based on the assessment of the combined performance for the performance category and performance period.

VBP eligible professionals who elect to become a virtual group would be required to do so before the beginning of a performance period and would not be allowed to change

status during the performance period. Each practice and each VBP eligible professional in such a practice could elect to be in no more than one virtual group for a performance period.

VBP incentive payments would be distributed in a budget neutral manner. The total amount for VBP program incentive payments for all VBP eligible professionals for a year would be equal to the total amount of the performance funding pool for all VBP eligible professionals as estimated by the Secretary (described below).

For items and services furnished by a VBP eligible professional, the Secretary would conduct two concurrent calculations to determine the amount paid: (1) a reduction of the otherwise applicable fee schedule amount for that year (see the applicable percent for the performance funding pool described below); and (2) a calculation of the VBP incentive payment amount (also described below). Eligible professionals would be notified of the adjustments that would be made to calculate the amount paid for items and services prior to the year in which payments are made.

The pool for paying VBP incentive payments would be created by reducing the otherwise applicable fee schedule amount, which is defined as the fee schedule amount for items and services furnished by an eligible professional that would otherwise apply. Beginning with 2017, the fee schedule amount for items and services provided by a VBP eligible professional would be reduced by the specified percentage described below (called the 'applicable percent'). The cumulative amount of such reductions for a year across all VBP eligible professionals would constitute the 'performance funding pool' for the year. The applicable percent reduction would be 4 percent for 2017, 6 percent for 2018, 8 percent for 2019, 10 percent for 2020, and in subsequent years, a percentage to be specified by the Secretary, but no less than 10 percent and no more than 12 percent.

The Secretary would specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year, which would be determined by the composite performance score of the eligible professional for the year. The adjustment factors would result in differential payments reflecting the full range of distribution of composite performance scores of VBP eligible professionals with professionals having higher composite performance scores receiving higher payments. The adjustment factors in a year could not result in a payment reduction that exceeds the applicable percent for a year, and could not result in a payment increase that exceeds the applicable percent for such year.

The VBP program incentive payment amount for items and services furnished by a VBP eligible professional during a year would be equal to the difference between:

1. the product of (a) the VBP program incentive payment adjustment factor and (b) the otherwise applicable fee schedule amount ; and
2. the otherwise applicable fee schedule amount, as reduced by the applicable percent above, with respect to such items and services, eligible professional,

and year.

The application of the preceding sentence may result in the VBP program incentive payment amount being 0.0 with respect to an item or service furnished by a VBP eligible professional.

With respect to items and services furnished by a VBP eligible professional during a year, the otherwise applicable fee schedule amount, as previously reduced by the specified percentage above, would be increased, if applicable, by the VBP program incentive payment amount.

In specifying the VBP program incentive payment adjustment factor for each VBP eligible professional for a year, the Secretary would ensure that the total amount of VBP program incentive payment amounts for all VBP eligible professionals in a year would be equal to the performance funding pool for the year, as estimated by the Secretary.

No later than 60 days prior to the year involved, the Secretary would make available to each VBP eligible professional (1) the VBP program incentive payment adjustment factor and (2) the percentage payment reduction for the performance funding pool applicable to the eligible professional for items and services furnished by the professional as described above for the year. The Secretary could include such information in confidential feedback reports (see below).

The VBP program incentive payment and the payment reduction described above would each apply only with respect to the year involved, and the Secretary would not take such VBP program incentive payments or payment reductions into account in making payments to a VBP eligible professional in a subsequent year.

The Secretary would make information regarding the performance of VBP eligible professionals under the VBP program available to the public, in an easily understandable format on the Physician Compare website. This information would include (1) the composite score for each VBP eligible professional, (2) the performance of each VBP eligible professional with respect to each performance category, and (3) the names of eligible professionals in eligible alternative payment models (described below) and, to the extent feasible, the name of the alternative payment model. The information could also include the performance of each VBP eligible professional with respect to each performance category measure or activity. The Secretary would provide for an opportunity for an eligible professional to review, and submit corrections to, the individual's information to be made public prior to such information being made public.

The Secretary would periodically post aggregate information on the VBP program on the Physician Compare website, including (1) the range of composite scores for all VBP eligible professionals, and (2) the range of the performance of all VBP eligible professionals with respect to each performance category.

The Secretary would consult with stakeholders in carrying out the VBP program,

including for the identification of performance category measures and activities and the methodologies for developing the composite score and the VBP program incentive payment adjustment factors. These consultations would include the use of a request for information or other mechanisms determined appropriate.

The Secretary would enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to VBP eligible professionals in practices of ten or fewer professionals (with priority given to practices in rural areas, in health professional shortage areas, or with low composite scores). The guidance and assistance would be provided with respect to (1) the performance categories, and (2) how to transition to the implementation of and participation in an alternative payment model.

For purposes of implementing the guidance and assistance described above, the Secretary would provide for the transfer of \$25 million from the Supplementary Medical Insurance (SMI) Trust Fund to the CMS Program Management Account for each of fiscal years 2014 through 2018. These amounts would be available until expended.

Beginning July 1, 2015, the Secretary would make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the individual's performance with respect to the quality and resource use performance categories. The Secretary could also make available confidential feedback on the individual's performance with respect to the clinical practice improvement activities performance category and the meaningful use of certified EHR technology category. The Secretary could use one or more mechanisms to provide this feedback, including use of a web-based portal or other mechanisms determined appropriate by the Secretary. The Secretary would encourage provision of feedback through qualified clinical data registries under the existing PQRS program (as implemented by the ATRA of 2012). The Secretary could also use such mechanisms to receive information from professionals.

To facilitate timely feedback, the Secretary could use data, with respect to VBP eligible professionals, from periods prior to the current performance period and could use rolling periods in order to make illustrative calculations about the performance of these professionals. This feedback would be exempt from disclosure under the Freedom of Information Act (FOIA).

Beginning July 1, 2016 the Secretary would make available, to each VBP eligible professional, information about selected items and services (as determined appropriate by the Secretary) furnished to the professional's patients by other suppliers and providers of services for which Medicare payment is made. This information on selected items and services furnished to patients of a VBP eligible professional by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), would be the following: (1) the name of such providers furnishing items and services to such patients during the period, the types of items and services so furnished, and the dates on which these items and services were furnished; and (2) historical averages (and other measures of the distribution if

appropriate) of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) for care episode codes for such period. Such information would be made available to VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information shall be made available on the same or similar terms as data are made available to accountable care organizations under section 1899 of the SSA, including a beneficiary opt-out.

The Secretary would establish a process under which a VBP eligible professional could seek an informal review of the calculation of the individual's VBP program incentive payment adjustment factor. The results of such a review would not be taken into account for purposes of determining the VBP program incentive payment adjustment factors with respect to a year (other than with respect to the calculation of such eligible professional's VBP program incentive payment adjustment factor for such year).

There would be no administrative or judicial review of the following: (1) the methodology used to determine the amount of the VBP program incentive payment adjustment factor and the determination of such amount; (2) the determination of the amount of funding available for such VBP program incentive payments and the payment reduction described above; (3) the establishment of the performance standards and the performance period; (4) the identification of performance category measures and activities and information made public or posted on the Physician Compare website; and (5) the methodology developed and used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

The GAO would submit two VBP program evaluation reports to the Congress, due October 1, 2018 and October 1, 2021. These reports would include (1) an examination of the distribution of the performance and incentive payments for VBP eligible professionals and patterns relating to the performance and incentive payments, including an analysis based on the type of provider, practice size, geographic location, and patient mix, and (2) provide recommendations for improving the program.

The GAO would also submit a report to Congress, not later than 18 months after enactment, which would compare the similarities and differences in the use of quality measures under the Medicare fee-for-service program, the Medicare Advantage program, and private payer arrangements. The report would make recommendations on how to reduce the administrative burden involved in applying such quality measures.

For purposes of implementing the VBP program, the Secretary would provide for the transfer from the SMI Trust Fund to the CMS Program Management Account of \$50 million for each fiscal year from 2014 through 2017. Amounts transferred would remain available until expended.

The Chairman's Mark includes several modifications to improve quality reporting for the VBP program. The provision clarifies and allows group practices to meet satisfactory

reporting requirements for group practices by reporting to qualified clinical data registries beginning in 2015 and subsequent years. Similarly, current requirements for satisfactory reporting under the PQRS program are simplified, beginning in 2014 and in subsequent years, by allowing (but not requiring) the Secretary to establish alternative criteria for satisfactorily reporting such as reporting groups of measures under the PQRS program and to establish an alternative reporting period. The satisfactory reporting of measures for group practices would be modified for 2014 and subsequent years by allowing for, but not requiring, the use of a statistical sampling model to submit data on measures.

Reports under the physician feedback program would not be provided after December 31, 2016 and instead would be provided under the requirements of the VBP program (described above).

To promote alternative payment models (APM), the Chairman's Mark establishes incentive payments for eligible professionals who become qualifying participants in an eligible APM. For covered professional services furnished by a qualifying APM participant from 2017 through 2022, such professionals would be paid an amount equal to 5 percent of the payment amount for the Medicare-covered professional services for the preceding year (which may be an estimate for the full preceding year based on a period that is less than the full year). The Secretary would establish policies to implement the additional payment in cases where payment for covered professional services furnished by a qualifying APM participant in an APM is made to an entity participating in the APM rather than directly to the participant. Payment would be made in a lump sum, on an annual basis, as soon as practicable. APM incentive payments would not be taken into account for purposes of determining actual expenditures or rebasing any benchmarks used under the alternative payment model.

The amount of the additional payment for an item or service made to a qualifying APM participant would be determined without regard to additional payments for items and services furnished to professionals in health professional shortage areas (under section 1833(m) of the SSA), additional incentive payments for primary care services (under section 1833(x) of the SSA), or additional incentive payments for major surgical procedures furnished in health professional shortage areas (under section 1833(y) of the SSA).

The term "APM" would be defined to mean any of the following:

- a) A model under the Center for Medicare and Medicaid Innovation defined under section 1115A of the SSA (other than a health care innovation award).
- b) A Medicare Shared Savings Program accountable care organization (defined under section 1899 of the SSA).
- c) A demonstration under section 1866(C) of the SSA.
- d) A demonstration required by federal law.

The term “eligible APM” would mean, with respect to a year, an APM that (1) uses certified EHR technology (defined under section 1848(o)(4) of the SSA), (2) provides for payment for covered professional services based on quality measures comparable to the VBP quality performance category, and (3) satisfies the requirement that the APM (1) bears financial risk for monetary losses under such model that are in excess of a nominal amount, or (2) is a medical home expanded under the Center for Medicare and Medicaid Innovation (under section 1115A(c) of the SSA).

The term “qualifying APM participant” would mean the following:

- (1) with respect to 2017 and 2018, an eligible professional for whom the Secretary determines that at least 25 percent of payments for Medicare-covered professional services furnished by the professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;
- (2) with respect to 2019 and 2020, an eligible professional for whom the Secretary determines that:
 - a. Medicare-only revenue threshold option - at least 50 percent of payments under Medicare Part B for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM; or
 - b. Medicare and all-payer revenue threshold option –
 - i. at least 25 percent of payments under this part were for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to service furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;
 - ii. at least 50 percent of the sum of (I) payments made under Medicare Part B, and (II) all other payments regardless of payer (other than the Veterans Administration and Tricare) for items and services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such items and services for which such professional is paid based on quality measures comparable to the VBP quality performance category, bears financial risk for monetary losses that are in excess of a nominal amount and for

whom the Secretary determines, and uses certified HER technology (as defined under section 1848(o)(4) of the SSA); and

- iii. who provides the Secretary such information as is necessary for the Secretary to make a determination regarding the percent of revenue received under (ii) above.

(3) with respect to 2021 or a subsequent year, an eligible professional for whom the Secretary determines that:

- a. Medicare only revenue threshold option - at least 75 percent of payments under Medicare Part B for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;
- b. Medicare and all-payer revenue threshold option –
 - i. at least 25 percent of payments under this part were for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to items and services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;
 - ii. at least 75 percent of the sum of (I) payments made under Medicare Part B, and (II) all other payments regardless of payer (other than the Veterans Administration and Tricare) for items and services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such items and services for which such professional is paid based on quality measures comparable to the VBP quality performance category, bears financial risk for monetary losses that are in excess of a nominal amount and for whom the Secretary determines, and uses certified HER technology (as defined under section 1848(o)(4) of the SSA); and
 - iii. who provides the Secretary such information as is necessary for the Secretary to make a determination regarding the percent of revenue received under (ii) above.

A “partial qualifying APM participant” would be defined as an eligible professional who would fail to meet the appropriate revenue threshold to achieve a bonus payment under the qualified APM program but who met the thresholds defined below. Although a partial qualifying APM participant could choose to participate in the VBP program for a year

(and receive VBP incentive payments for that year), the eligible professional would be held harmless for lack of participation in the VBP program if the appropriate revenue thresholds were met, as follows:

1. for 2017 and 2018, the partial qualifying APM threshold would be set at 20 percent of Medicare revenue;
2. for 2019 and 2020, the partial qualifying APM threshold would be set at 40 percent of Medicare revenue; or 40 percent of all-payer revenue and 20 percent of Medicare revenue; and
3. for 2021 and subsequent years, the partial qualifying APM threshold would be set at 50 percent of Medicare revenue or 50 percent of all-payer revenue and 20 percent of Medicare revenue.

The term “covered professional services” would have the same meaning as defined for purposes of the PQRS program (under section 1848(k)(3)(A) of the SSA).

The term “eligible professional” would have the same meaning as defined for purposes of the PQRS program (under section 1848(k)(3)(B) of the SSA).

There would be no administrative or judicial review of the following: (1) the determination that an eligible professional is a qualifying APM participant as described above and the determination that an APM is an eligible APM; and (2) the determination of the amount of the 5 percent payment incentive including any estimation as part of this determination.

To encourage the development and testing of additional APMs, section 1115A(b)(2) would be amended to encourage CMMI to test models focusing primarily on physicians’ services (as defined under section 1848(j)(3) of the SSA), with particular focus on (1) such services furnished by physicians who are not primary care practitioners, (2) practices of ten or fewer professionals, and (3) statewide payment models, in addition to other public sector or private sector payers.

The Secretary would conduct a study that examines the applicability of the federal fraud prevention laws to items and services furnished under the Medicare program for which payment is made under an APM. The study would identify aspects of APMs that are vulnerable to fraudulent activities and examine the implications of waivers of federal fraud prevention laws granted by the Secretary in support of APMs (including any expansion of APMs).

Not later than two years after the date of enactment, the Secretary would report to Congress on the results of the study. The report would be required to include recommendations for actions to be taken to reduce vulnerability of APMs to fraudulent activities (including, as appropriate, recommendations of the Inspector General for changes in federal fraud prevention laws).

The Secretary would also conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program. The study would collect information factors such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across states), and eligibility for benefits under the supplemental security income program. Not later than two years after the date of enactment, the Secretary would report to Congress on the results of the study.

The Secretary would also conduct another study examining the impact of risk factors described under the value-based payment modifier established under the SSA, as well as other factors such as health literacy, limited English proficiency, patient activation, and race, on quality and resource use outcomes measures under the Medicare program. In conducting the study, the Secretary could use existing federal data and collect additional data that may be necessary to complete the study. Not later than five years after the date of enactment, the Secretary would report to Congress on the results of the study.

In conducting the studies, the Secretary would examine other useful non-Medicare data sets such as data from the American Community Survey. The Secretary would also consider how such data sets can be coordinated with Medicare administrative data, in order to improve the overall data set available to complete the studies and for the administration of the Medicare program.

If the studies find a relationship between the factors examined and quality and resource use outcome measures, then the Secretary would also provide recommendations to CMS on:

- (1) ways to obtain access to the necessary data (and how to address barriers to data collection); and
- (2) ways to account for such factors in determining payment adjustments based on quality and resource use outcome measures under the VBP program and other similar provisions under the Medicare program.

To fund these studies, \$10 million would be appropriated from the SMI Trust Fund to the Secretary. These funds would remain available until expended.

Taking into account the relevant studies conducted and recommendations made, the Secretary, on an ongoing basis, would estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the VBP program and, as the Secretary determines appropriate other similar provisions of the Medicare program.

Taking into account the studies conducted and recommendations made, the Secretary would account for factors identified with an effect on quality and resource use outcome

measures when determining payment adjustments under the eligible professional VBP program and, as the Secretary determines appropriate, other similar Medicare provisions.

The Secretary would collect or obtain data necessary to account for factors besides health status. The Secretary would carry out periodic analyses, at least every three years, based on factors other than health status so as to monitor possible changes in relationships between factors examined and quality and resource use outcome measures.

To fund these activities, \$10 million would be appropriated from the SMI Trust Fund to the Secretary. These funds would remain available until expended.

Not later than 18 months after the date of the enactment of this Act, the Secretary will develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out the Medicare program.

The Secretary would engage in a process, collaborating with physician, practitioner, and other stakeholder communities, to improve resource use measurement. The Secretary would be required to develop a classification system and codes in order to classify similar patients into distinct care episode and patient condition groups for purposes of measuring resource use. No later than 60 days after enactment, the Secretary would post a list on the CMS website of the episode groups and a related description of the grouping criteria developed pursuant to the episode grouper required under section 1848(n)(9)(A) of the SSA. The Secretary would accept suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for additional episode groups as well as specific clinical criteria and patient characteristics to classify similar patients into (1) distinct care episode groups, and (2) distinct patient condition groups after the Secretary posts the list to the CMS website for 60 days.

To develop the proposed classification codes, the Secretary would (1) establish distinct care episode groups and distinct patient condition groups which account for at least an estimated two-thirds of expenditures under Medicare Parts A and B, and (2) assign codes to these groups.

In establishing the care episode groups, the Secretary would base the groups on the following:

- (1) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and
- (2) other factors determined appropriate by the Secretary.

In establishing the patient condition groups, the Secretary would base the groups on the following:

(1) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during the previous three months); and

(2) other factors determined appropriate by the Secretary, such as Medicare eligibility status and dual eligibility under Medicare and Medicaid.

The Secretary would be required to post a draft list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website within 120 days after the stakeholder comment deadline. The Secretary would then seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the draft list and use one or more mechanisms that could include use of open door forums, town hall meetings, or other appropriate mechanisms.

Not later than 120 days after the end of the comment period, the Secretary would post an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to the code) on the CMS website, taking into account the comments received.

Beginning with 2016, the Secretary would formalize the update process and make appropriate revisions to the operational lists of care episode and patient condition codes by November 1 of each year, through rulemaking. Such revisions could be based on experience, new information developed pursuant to the development of the episode grouper required under Section 1848(n)(9)(A) of the SSA, and input from physician specialty societies, applicable practitioner organizations, and other stakeholders.

To facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners who provided their care, the Secretary would undertake the following:

1. Develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of providing an item or service. These patient relationship categories would include different relationships of the physician or applicable practitioner to the patient (and the codes could reflect combinations of such categories), such as a physician or applicable practitioner who:
 - a. considers himself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
 - b. considers himself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

- c. furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
 - d. furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
 - e. furnishes items and services only as ordered by another physician or practitioner.
2. Post the draft list of patient relationship categories and codes on the CMS website within 180 days after the date of enactment.
3. Seek comments, through the date that is 60 days after the Secretary posts the list of draft patient relationship categories and codes, from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the patient relationship categories and codes as posted. In seeking such comments, the Secretary would use one or more mechanisms that may include open door forums, town hall meetings, or other appropriate mechanisms.
4. Post an operational list of patient relationship categories and codes on the CMS website not later than 120 days after the end of the comment period, taking into account the comments received.
5. Make revisions to the operational list of patient relationship categories and codes as appropriate not later than November 1 of each year (beginning with 2016), through rulemaking. Such revisions could be based on experience, new information developed pursuant to the development of the episode grouper required under section 1848(n)(9)(A) of the SSA, and input from physician specialty societies, applicable practitioner organizations, and other stakeholders.

Beginning on January 1, 2016, any claim for payment for items or services furnished by a physician or applicable practitioner would have to include, as determined appropriate by the Secretary, care episode and patient condition codes and patient relationship codes, and the national provider identifier (NPI) of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

In order to evaluate the resources used to treat patients with respect to care episode and patient condition groups, the Secretary would conduct an analysis using the patient relationship codes reported on claims to attribute patients (in whole or in part) to one or more physicians and applicable practitioners, and using the care episode and patient condition codes reported on claims as a basis to compare similar patients and care episodes and patient condition groups.

This resource use analysis would, as feasible, use the claims data experience of patients during a common period, such as 12 months, for patient condition codes. In addition, the analysis would use the claims data experience by care episode codes for defined periods

of time as determined appropriate by the Secretary. For non-hospitalization services, the defined period could be the number of days of care, while the period for episodes with a hospitalization could be the number of days before, during, and after the hospitalization.

In measuring the resource use, the Secretary would use per patient total allowed charges for all services under Medicare Part A, Part B and, if the Secretary determines appropriate, Part D, for the analysis of patient resource use, by care episode codes and by patient condition codes. The Secretary could use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes), as appropriate.

The Secretary would seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the resource use methodology established above. In seeking comments, the Secretary would use one or more mechanisms (other than notice and comment rulemaking) that could include open door forums, town hall meetings, or other appropriate mechanisms.

There would be no administrative or judicial review of (1) the care episode and patient condition groups and codes, (2) patient relationship categories and codes, or (3) measurement of, and analyses of resource use with respect to, the care episode and patient condition codes and patient relationship codes.

Requirements under current law (Chapter 35 of title 44, United States Code) regarding coordination of federal information, including the Paperwork Reduction Act, would not apply to this section.

For purposes of the resource use program described in this section, the term ‘physician’ would have the same meaning as under current Medicare law, the term ‘applicable practitioner’ would mean (1) a physician assistant, nurse practitioner, or clinical nurse specialist (as such terms are defined under current law), and (2) beginning January 1, 2017, other eligible professionals as specified by the Secretary.

The Chairman’s Mark process for collaborating with the physician, practitioner, and other stakeholder communities to measure resource use falls outside of the process of multi-stakeholder input for measure development.

Sec. 103. Priorities and Funding for Quality Measure Development

Current Law

Currently, measures for physicians and practitioners are concentrated in certain specialties and services while other services and specialties have few or no measures. In addition, many current measures are process measures rather than the preferred type of measures such as for outcomes, functional status, patient experience, care coordination and measures of overuse of services.

Chairman's Mark

The Chairman's Mark would amend section 1848 of the Social Security Act SSA to add a new subsection (s), "Priorities and Funding for Quality Measure Development." The Secretary would be required, not later than October 1, 2013, to develop a draft plan for the development of professional quality measures for application in the quality performance category under the new value-based performance program and comparable quality measures used by an APM. Such plan would be required to address how measures used in integrated delivery systems and by private payers could be incorporated under this subsection. In developing the plan, the Secretary would be required to consider gap analyses conducted by the entity with a contract under Section 1890(a) of the SSA or other contractors or entities and whether measures are applicable across health care settings. In addition, the Secretary would be required to prioritize, among other things, outcome measures, including patient-reported outcome and functional status measures, patient experience measures, care coordination measures, and measures of overuse of services.

The Secretary would be required to accept stakeholder comments, through December 1, 2014, on the draft plan, and would be required to, not later than February 1, 2015, post on the CMS website an operational plan for the development of quality measures for use under the value-based performance program.

Under the Chairman's Mark, the Secretary would also be required to enter into contracts or other arrangements with entities (such as physician specialty societies and other practitioner organizations) to develop, improve, update, or expand quality measures. . In entering into contracts, the Secretary would be required to give priority to measures that are prioritized in the draft plan. In addition, the Secretary must consider whether measures developed would be electronically specified.

The Secretary would be required, not later than February 1, 2016 and annually thereafter, to post on the CMS website a report on the progress made in developing quality measures for application as specified. The reports would be required to include the following: (1) a description of the Secretary's efforts to implement the subsection; (2) for the measures developed over the previous year, including information on the total and type of measures developed, the name of each measure developed, the name of the developer and steward for each measure, and an estimate of the total amount expended to develop the measures (this information must also be provided for measures in development, as well as a timeline for development completion); (3) an update on the progress in developing measures of outcome, patient experience of care, care coordination, and overuse; (4) a list of topics and concepts that are being considered for development and the rationale for the selection of topics and concepts, including their relationship to gaps analyses; (5) a description of updates to the plan and the inventory of applicable measures maintained by CMS; and (6) other information as the Secretary determines would be appropriate.

The Secretary would be required to seek stakeholder input with respect to: (1) the identification of gaps where no measures exist, and specifically with respect to measures of outcomes, patient experience of care, care coordination, and overuse; (2) prioritization of quality measure development to address such gaps; and other quality measure development areas, as determined by the Secretary.

The Secretary would be required to provide for the transfer of \$15 million, for each of FY2014 through FY2018, from the SMI Trust Fund to the CMS Program Management Account. The funds would remain available through FY2021.

Sec. 104. Encouraging Care Management for Individuals with Chronic Care Needs.

Current Law

Physicians are paid under the physician fee schedule for services provided to Medicare beneficiaries. The most common services are for evaluation and management (E/M), which are often associated with a typical physician office visit. Generally, to receive payment, there must be a face-to-face visit with the patient. Beneficiaries with chronic care needs often require care management services. Payments for E/M visits are calculated to include some non-face-to-face care management. However, these codes do not reflect all of the services and resources required to furnish comprehensive coordinated care management services for beneficiaries with chronic needs.

In the calendar year 2014 Medicare physician fee schedule final rule, CMS established a new payment for professionals for managing Medicare patients' chronic conditions in addition to payments professionals already receive for treating the patient's presenting condition. These new payments are separately payable for non-face-to-face chronic care management services. The chronic care management payment would apply to Medicare fee-for-service beneficiaries with multiple chronic conditions expected to persist for at least 12 months or until the patient's death. The conditions must put patients at significant risk of death, acute exacerbation/decomposition, or functional decline. The new payment would be for 20-minutes of management services that physicians can deliver over a 30-day period.

Chairman's Mark

The Chairman's Mark directs the Secretary to establish one or more Healthcare Common Procedure Coding System (HCPCS) codes for chronic care management services for individuals with chronic care needs. The Secretary would make payment for such management services furnished on or after January 1, 2015 by an applicable provider.

Applicable providers would be defined as providers who furnish services as part of a patient-centered medical home or comparable specialty practice that is certified by an organization recognized by the Secretary, or who meet other comparable qualifications that the Secretary determines to be appropriate. Applicable providers eligible to receive

care management payments include a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine or optometry, or a chiropractor licensed by the state to perform certain services recognized by the Social Security Act. The Chairman's Mark also defines an applicable provider as a physician assistant or nurse practitioner who performs such services as are legally authorized by the state. Finally, the Chairman's Mark recognizes clinical nurse specialists licensed to practice nursing in the state in which clinical nurse specialist services are performed as an applicable provider.

In establishing new HCPCS codes for chronic care management services, the budget neutrality provision of the physician fee schedule would still apply.

Payment for chronic care management services would only be made to one applicable provider during a period on behalf of each beneficiary. Payments for such management services could not be duplicative of payments for other services, such as hospice or home health services. Finally, payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

Sec. 105. Ensuring Accurate Valuation of Services under the Physician Fee Schedule.

Current Law

Payment is made under the Medicare physician fee schedule for more than 7,000 services. Payment is equal to the sum of the relative value units (RVU) – adjusted for geographic differences in costs - for physician work, practice expense, and malpractice for each service. A RVU reflects the relative resources of one physician fee schedule service compared to another.

The Secretary is responsible for establishing the fee schedule, including the modification and refinement of the methodology for establishing RVUs. In establishing RVUs, the Secretary receives recommendations from the public including the American Medical Association / Relative-Value Scale Update Committee (RUC). Modifications to RVUs for a service are done in a budget neutral manner. Thus, payment increases from changes to the RVUs for some services must be offset by reductions in payment for all other physicians' services. The Secretary is required to review the RVUs no less than every five years.

Currently when the Secretary calculates RVUs, the results can be very minor relative value differences that do not reflect material differences in the work, practice expense and malpractice relative value difference. For example, the difference between 18.61 and 18.62 does not reflect a material difference between services.

Section 1848(c)(2)(K) of the Social Security Act (SSA) requires the Secretary to periodically identify physicians' services as being potentially misvalued, and to make

appropriate adjustments to the RVUs of such services under the Medicare physician fee schedule. To identify potentially misvalued services, the Secretary is to examine codes (and families of codes as appropriate) with the fastest growth, that have experienced substantial changes in practice expenses, for new technologies or services, that are frequently billed in conjunction with furnishing a single service, with low relative values, particularly those that are often billed multiple times for a single treatment, that have not been subject to review since the implementation of the RBRVS (the so-called ‘Harvard-valued codes’), and other codes the Secretary determined to be appropriate.

In its March 2013 report, MedPAC recommended that Congress direct the Secretary to identify over-priced fee-schedule services and that the RVU reductions should achieve a target of 1 percent of fee-schedule spending for each of five consecutive years. MedPAC’s recommendation stated that the reductions should be budget neutral within the fee schedule.

Chairman’s Mark

Under the Chairman’s Mark, the Secretary could collect information on the resources used by an eligible professional to provide services that are paid under the Medicare physician fee schedule. This information could be collected or obtained from any eligible professional or any other source.

The Secretary could use this information in the determination of relative values for physician services paid for under the physician fee schedule.

Under the Chairman’s Mark, the Secretary could collect or obtain any or all of the following types of information: (1) the time to perform each service; (2) amounts and types of practice expense resources needed to perform each service; (3) the prices of practice expense resources needed to perform each service, which may include paid invoices or other documentation or records; (4) overhead and accounting information of physicians’ practices; or (5) any other element that would improve the valuation of physician services.

The Secretary could use any of the following mechanisms to collect or obtain the information listed above: (1) surveys of physicians, other suppliers, providers, manufacturers and vendors; (2) surgical logs, billing systems, or other practice or facility records; (3) electronic health records; and (4) other mechanisms determined appropriate by the Secretary.

The Secretary must report the source of information collected or obtained in the determination of relative values for physician services. The Secretary must also report how such information was used in the determination of relative values through notice and comment rulemaking. The Secretary may also exclude information collected or obtained from physicians who use a very high amount of resources to furnish services.

Information used to determine relative values for services that are reported by the Secretary will only be made available in aggregate form and will not disclose information that identifies an eligible professional or a group practice or information collected or obtained pursuant to a nondisclosure agreement. The Federal Information Policy (Chapter 35 of Title 44) will not apply to information collected or obtained.

In order to incentivize physicians to provide information, the Secretary could provide for payments to eligible professionals who submit information.

“Eligible professionals” are those that meet the definition of section 1848(k)(3)(B) of the SSA which includes: (1) physicians, (2) physician assistants, (3) nurse practitioners, (4) clinical nurse specialists, (5) certified registered nurse anesthetists, (6) certified nurse midwives, (7) clinical social workers, (8) clinical psychologists, (9) registered dietitian or nutrition professionals, (10) physical or occupational therapists, (11) qualified speech-language pathologists, and (12) qualified audiologists.

In addition to funds otherwise appropriated, the Secretary will provide for the transfer of \$2 million from the Supplementary Medical Insurance Trust Fund to the CMS program Management Account for each fiscal year beginning with FY 2014. Amounts transferred for a fiscal year will be available until expended.

There would be no administrative or judicial review of the collection and use of information in the determination of relative values.

The Secretary could use cost, charge, and other information collected or obtained from suppliers and providers to determine the practice expense relative values for physician services, including the new information collected under this provision.

The Chairman’s Mark expands the criteria the Secretary must use for identifying potentially misvalued codes to (1) codes that account for the majority of spending under the physician fee schedule; (2) codes for services that have experienced a substantial change in the hospital length of stay or procedure time; (3) codes for which there may be a change in the typical site of service since the code was last valued; (4) codes for which there is a significant difference in payment for the same service between different sites of service; (5) codes for which there may be anomalies in relative values within a family of codes; (6) codes for services where there may be efficiencies when a service is furnished at the same time as other services; (7) codes with high intra-service work per unit of time; (8) codes with high practice expense relative value units; and (9) codes with high cost supplies.

With respect to fee schedules established for each year of 2015 through 2018, the Secretary must determine the estimated net reduction in expenditures under the fee schedule for a year as a result of adjustments to the relative values for misvalued codes. The Chairman’s Mark sets a target of 0.5 percent of the estimated amount of expenditures under the fee schedule for each year of 2015 through 2018 for such reductions.

If the estimated net reduction in expenditures for the year is equal to or greater than the 0.5 percent target for the year, reduced expenditures attributable to such adjustments will be redistributed in a budget neutral manner within the physician fee schedule. Any reductions in excess of the target will be treated as a reduction in expenditures for purposes of meeting the target for the following year.

If the estimated net reduction in expenditures for the year is less than the 0.5 percent target, the difference between the target and the estimated net reduction in expenditures will not be subject to budget neutrality and fee schedule payments will be reduced by that difference.

Beginning in 2015, if the total reduction of the relative value units (including work, practice expense, and malpractice) for a service for a year is more than 20 percent of the total value of the relative value units for the previous year, the applicable reductions in work, practice expense, and malpractice relative value units will be phased in over a two year period.

The Chairman's Mark would give the Secretary authority to smooth minor differences in relative values for families or groups of procedures.

Not later than one year after enactment, the Government Accountability Office (GAO) will conduct a study of the processes used by Relative Value Scale Update Committee to provide recommendations to the Secretary regarding the relative values for specific services under the physician fee schedule.

Sec. 106. Promoting Evidence-Based Care

Current Law

Medicare pays for outpatient imaging services through the physician fee schedule. Following findings from MedPAC, GAO, and others that the rate of growth in Medicare outpatient imaging services was greater than for most other Medicare covered services, Congress and CMS have initiated a number of policies to address the issue. The Deficit Reduction Act (DRA, P.L. 109-171) modified the payment rules for certain imaging services by capping the technical component of the payment for services paid under the physician fee schedule at the level paid under the hospital outpatient prospective payment system effective January 1, 2007. Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy.

CMS, in the November 2005 physician fee schedule regulations, extended the multiple procedure payment reduction policy to certain imaging services. The payment reduction was 25 percent of the technical component of certain imaging procedures performed on contiguous body areas. Under section 1848(c)(2)(b)(vi) of the Social Security Act (SSA) the reduction is increased to 50 percent effective July 2010. CMS expanded the application of the payment reduction to studies on noncontiguous body areas and the

professional component for the second and subsequent services to the same patient, in the same session, on the same day.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services originally assumed that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at a lower rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90 percent, rather than the 50 percent previously assumed, MedPAC urged CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services. The Affordable Care Act (P.L. 111-148) changed the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent, as assumed in prior years, to 75 percent for 2011 and in subsequent years. The American Taxpayer Relief Act (P.L. 112-240) requires the Secretary to apply a 75 percent use rate in calculating payment rates for advanced imaging services through 2013, and a 90 percent use rate for 2014 and subsequent years.

To further address the rapid growth in advanced imaging services, MedPAC recommended in its June 2011 report that Congress direct the Secretary to establish a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers.

Chairman's Mark

This section of the Chairman's Mark will promote the use of evidence-based medical care. Specifically, it will create a program to promote utilization of appropriate use criteria by ordering professionals for certain imaging services in designated settings. Appropriate use criteria are criteria used to assist ordering professionals in making the most appropriate treatment decision for a specific clinical condition. The Chairman's Mark requires professionals to consult appropriate use criteria as a prerequisite to Medicare payment for the applicable imaging service.

The following professionals will be subject to these requirements: (1) medical doctors and osteopaths, (2) dentists, (3) podiatrists, (4) optometrists, (5) chiropractors, (6) physician assistants, (7) nurse practitioners, (8) clinical nurse specialists, (9) certified nurse anesthetists, (10) certified nurse-midwives, (11) clinical social workers, (12) clinical psychologists, and (13) registered dietitians or nutritional professionals. Ordering professionals are defined as a professional who orders an applicable imaging service for an individual. Furnishing professionals are defined as a professional who furnishes an applicable imaging service for an individual.

Applicable imaging services are those advanced diagnostic imaging services defined in Section 1834(e)(1)(B) of the SSA for which there are one or more appropriate use criteria specified by the Secretary through rulemaking and at least one or more qualified clinical decision support mechanisms that are free of charge.

These requirements apply for diagnostic imaging services furnished in the following settings: (1) physicians' offices, (2) hospital outpatient departments, (3) ambulatory surgical centers, (4) and any other outpatient setting determined appropriate by the Secretary. Applicable payment systems are the physician fee schedule, the outpatient prospective payment system, and the ambulatory surgical center payment system.

The Secretary is required to specify appropriate use criteria by November 15, 2015 from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities. This must be accomplished through rulemaking and in consultation with physicians, practitioners, and other stakeholders. In specifying these criteria, the Secretary must consider whether the criteria have achieved stakeholder consensus, are scientifically valid and evidenced-based, and are in the public domain. The Secretary must periodically update and revise (as appropriate) the appropriate use criteria. In cases where more than one appropriate use criteria applies, the Secretary must specify one or more criteria that would be applicable.

In addition to these criteria, the Secretary must specify—in consultation with physicians, practitioners, and other stakeholders—one or more qualified clinical decision support mechanisms that can be used by ordering professionals to consult appropriate use criteria for the applicable imaging services. These mechanisms may include certified electronic health records (EHR) clinical decision support modules, private sector clinical support tools that are independent from certified EHR technology, including clinical decision support mechanisms available from medical specialty organizations, and other clinical decision support mechanisms established by the Secretary.

To be qualified, the clinical decision support mechanism must be able to make available to the ordering physician the applicable appropriate use criteria and supporting documentation, and also be able to determine the extent to which the ordering of an applicable image complies with the criteria. The mechanism must also be able to generate and provide to the ordering physician a certification or documentation that the criteria was consulted by the ordering physician. It also must be updated on a regular basis to reflect revisions to the criteria, comply with all applicable privacy and security standards, and be able to perform other functions specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering physician. The Secretary must provide a list of qualifying mechanisms by April 1, 2016 and update it periodically.

Beginning on January 1, 2017, an ordering professional in an applicable setting must consult appropriate use criteria via qualified clinical decision support mechanisms for applicable imaging services and provide the furnishing professional with the following: (1) information about which decision support mechanism was consulted by the ordering professional; (2) whether the ordered imaging service: a) adhered to the applicable appropriate use criteria, b) did not adhere; or c) the criteria were not applicable to the service ordered; and (3) the national provider identifier of the ordering professional (if different from the furnishing professional). Payment for the imaging service will only be made if the claim includes this information.

The appropriate use requirement will not apply to applicable imaging services ordered: (1) for individuals with an emergency medical condition, (2) for hospital inpatients, (3) by professionals in an APM, as defined under section 102 of the Chairman's Mark, and (4) by professionals who would face significant hardship consulting with appropriate use criteria, such as professionals whose practices are in a rural area without sufficient Internet access.

Using data from January 1, 2017 onward, the Secretary will periodically determine ordering professionals who are outliers based on their low adherence to appropriate use criteria, which may be based on comparisons to other ordering professionals. The Secretary's determination must also include data for professionals who are subject to prior authorization. In making these determinations, the Secretary must use two years of data and consult with physicians, practitioners, and other stakeholders in developing methods to identify outlier professionals.

Beginning on January 1, 2020, all applicable imaging services ordered by an outlier ordering professional will be subject to prior authorization. To fund this prior authorization program, \$5 million per year will be provided to CMS from the Supplementary Medical Insurance (SMI) Trust Fund from 2019 through 2021. Amounts transferred from the SMI Trust Fund will remain available until expended.

Based on the experience with the use of appropriate use criteria for imaging services, the Secretary may expand the appropriate use criteria program to other Part B services. In determining whether to establish additional program, the Secretary must also take into consideration the results of a GAO study - conducted 18 months after enactment - on the extent to which appropriate use criteria could be used for other services, such as radiation therapy and clinical diagnostic laboratory services. In addition, before issuing a proposed rule expanding appropriate use criteria to other Part B services, the Secretary must seek comments from stakeholders through an advanced notice of proposed rulemaking.

Sec. 107. Empowering Beneficiary Choices through Access to Information on Physician Services

Current Law

Section 10331 of the ACA requires the Secretary to develop, not later than January 1, 2011, a Physician Compare website with information about physicians enrolled in Medicare and other eligible professionals who participate in the Physician Quality Reporting Initiative (now the Physician Quality Reporting System (PQRS)). The Secretary was required, by January 1, 2013, to implement a plan to make publicly available comparative information on physician performance on quality and patient experience measures (consistent with privacy protections codified at 5 U.S.C. 552 and 552a).

The information on Physician Compare is required to include, among other things, measures collected under PQRS, and an assessment of efficiency, safety, patient health

outcomes, and patient experience. In developing and implementing this plan, the Secretary was required to consider a number of factors, including among others, processes to ensure appropriate attribution and processes to ensure that data made publicly available is statistically valid and reliable.

The Secretary is required to consider the feedback from the multi-stakeholder groups (consistent with sections 1890(b)(7) and 1890A of the SSA) when selecting measures for use under this section, and must consider the plan to transition to a value-based purchasing program for physicians (under section 131 of the Medicare Improvements for Patients and Providers Act) when developing and implementing the plan under this section. The Secretary is required to report to Congress, not later than January 1, 2015, on the Physician Compare website. At any time before the submission of this report, the Secretary is authorized to expand the information available on the Physician Compare website to other types of Medicare providers, and is authorized to establish, at any time not later than January 1, 2019, a demonstration program to provide financial incentives to Medicare beneficiaries who utilize high quality physicians (as determined by the Secretary based on information included on the Physician Compare website).

Chairman's Mark

The Chairman's Mark would codify section 10331 of the ACA into the SSA by creating a new section 1848(t). It would also direct the Secretary to post additional information on Physician Compare on eligible professionals.

The Secretary would include the following information on Physician Compare: (1) information on the number of services provided by each eligible professional, which could include information on the most frequent services furnished or groupings of services, (2) information on submitted charges and payments for services under Medicare Part B, and (3) a publicly available and unique identifier, such as a national provider identifier, for each eligible professional.

Physician Compare would be searchable by at least (1) the specialty or type of eligible professional, (2) the characteristics of the services furnished, such as the volume or groupings of services, and (3) the location of the eligible professional.

Physician Compare would also indicate, where appropriate, that the publicized information may not be representative of the eligible professional's entire patient population, the variety of services provided by the eligible professional, or the health conditions of individuals treated.

The Secretary would make this information available on Physician Compare by July 1, 2015, for physicians and by July 1, 2016, for other eligible professionals. The Secretary would also update Physician Compare on at least an annual basis.

Prior to making the information public, the Secretary would provide an opportunity for an eligible professional to review and submit corrections to the information on the eligible professional.

Sec 108. Expanding claims data availability to improve care

Current Law

Section 1874(e) of the SSA requires the Secretary to make claims data available that could be used to measure health care provider and supplier performance. This section enables qualified entities (QEs) to obtain standardized extracts, as determined by the Secretary, of Medicare Parts A, B, and D claims data for one or more specified geographic areas and time periods. The fees for making Medicare data available for performance measurement are to be equal to the cost of providing the data. The Secretary must take those actions necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts. CMS created the Qualified Entity Certification for Medicare Data Program and published a final rule that established regulations governing the program.

To be certified as a QE, entities must be qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. They also must agree to requirements governing the use of the data.

QEs are only permitted to use the Medicare data for publishing public performance reports on providers and suppliers. When requesting the Medicare data, a QE must submit to the Secretary a description of the methodologies that will be used to evaluate provider performance. They must also combine the CMS-provided data with claims data from another source. When creating reports, they must use standard measures if available. However, if necessary, they may use alternative measures in consultation with appropriate stakeholders. Additionally, the reports can only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary.

QE's public reports must include an understandable description of the measures, which include standard quality measures and the rationale for use of alternative measures, risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports. Prior to their public release, these reports must be made available confidentially, to any provider of services or supplier to be identified in such report, and provide them with an opportunity to appeal and correct errors. Prior their public release, the QEs must also make the format of the reports available to the Secretary.

Data released to a QE is not subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

Chairman's Mark

The Chairman's Mark would expand the availability of CMS claims data to qualified entities (QEs) and the ability of QEs to provide non-public analyses and access to their CMS data combined with their other data. The Chairman's Mark also would provide qualified clinical data registries with access to the same CMS claims data as QEs.

Beginning July 1, 2014, to the extent consistent with applicable information, privacy, security, and disclosure laws, a QE would, as determined appropriate by the Secretary, be able to use its CMS data combined with its other data to conduct analyses for non-public uses. The QE could provide or sell these non-public analyses to any of the following entities: (1) a provider of services or a supplier, (2) a medical society or hospital association, (3) a health insurance issuer providing claims data to the QE, (4) an employer, as defined under Section 3(5) of the Employee Retirement Insurance Security Act of 1974, but only for the purpose of providing health insurance to its employees, or (5) other entities approved by the Secretary. However, the Secretary could not grant access to analyses to an employer (under the Employee Retirement Insurance Security Act of 1974) for purposes other than providing health insurance to its employees or to a health insurance insurer that does not provide claims data to the QE.

QEs would be able to perform these non-public analyses for the following purposes: (1) helping providers develop and participate in quality and patient care improvement activities (including developing new models of care), (2) population health management, (3) disease monitoring, (4) assisting employers with providing health insurance to their employees, and (5) other purposes approved by the Secretary.

A QE analysis for a provider could include information individually identifying the provider's patients but only for services performed by the provider to the identified patients. In all other instances, QE analyses could not include any information that individually identifies a patient. An entity receiving an analysis from a QE could not redisclose or make the analysis public.

If a non-public analysis were to individually identify a provider that is not being provided or sold the analysis, the QE would have to provide the identified provider with an opportunity to review and submit corrections to the analysis.

A QE would also be able to provide or sell access to its CMS data combined with its other data through a qualified data enclave, defined as a web-based portal (or comparable mechanism) that is capable of providing access to the combined data maintained by the QE. The QE could provide or sell access to the enclave to any of the following entities: (1) a provider of services, (2) a supplier (3) a medical society or hospital association, and (4) other entities approved by the Secretary. However, the Secretary could not grant

access to the data through a qualified data enclave to an employer (under the Employee Retirement Insurance Security Act of 1974) or to a health insurance insurer.

These entities would only be permitted to use the data for the purposes of (1) assisting providers in developing and participating in quality and patient care improvement activities (including developing new models of care), (2) population health management, (3) disease monitoring, and (4) other purposes approved by the Secretary.

A data enclave would have to block entities accessing the data enclave from removing or extracting data from the enclave. The enclave would also have to block access to data that individually identifies a patient, including data on the patient's name and date of birth as well as other data specified by the Secretary. The data enclave could grant a provider or supplier with access to identified patient data, but only on services the provider or supplier performs for their patients. QEs cannot grant access to the data enclave to an entity (provider, medical society, etc.) unless the QE and the entity have entered into a data use agreement.

Any QE that would provide or sell non-public analyses or access to a qualified data enclave would have to submit to the Secretary an annual report that includes the following information: (1) a summary of the analyses provided or sold, including the number of analyses, the number of purchasers, and the total amount of fees received for the analyses; (2) a description of the topics and purposes of the analyses; (3) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of fees received for providing access; and (4) other information determined appropriate by the Secretary.

Beginning July 1, 2014, if the Secretary determines appropriate, the Secretary could provide to QEs standardized extracts (as the Secretary determines appropriate) of claims data under Medicaid and the Children's Health Insurance Program for assistance providing for one or more specified geographic areas and time periods requested by a QE. When issuing the data to QEs, the Secretary must take the appropriate actions needed to protect the identity of individuals entitled to or enrolled for these programs' benefits.

Beginning on July 1, 2014, QE fees paid to the Secretary for providing data extracts would be deposited in the CMS Program Management Account instead of the Federal Supplementary Medical Insurance Trust Fund.

To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, qualified clinical data registries would be able to purchase the same CMS claims data (in a form and manner determined appropriate by the Secretary) as QEs in order to link the data with clinical data and perform analyses and research to support quality improvement or patient safety.

Effective July 1, 2014, if the Secretary determines appropriate, the Secretary may make available standardized extracts under Medicaid and the Children's Health Insurance

Program for assistance providing for one or more specified geographic areas and time periods requested by a QE. Any fees the Secretary was to collect by making such data available would be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

A qualified clinical data registry could not publicly report any research, analyses, or CMS data that individually identifies a provider, supplier or individual unless the registry was to obtain the consent of the provider, supplier or individual prior to reporting.

Title II—Extensions and Other Provisions

Subtitle A—Medicare Extensions

Sec. 201. Floor on Geographic Adjustment for Physician Fee Schedule.

Current Law

The Medicare physician fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to provide physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are an index—known as Geographic Practice Cost Index (GPCI)—that reflect how each area compares to the national average. A value of 1.00 represents the average across all areas. This index is used in the calculation of the payment rate under the Medicare physician fee schedule. A series of bills set a temporary floor value of 1.00 on the physician work GPCI beginning January 2004 and continuing through December 31, 2013.

Chairman's Mark

The floor on the work geographic index would be kept at 1.0 for services provided through CY2014, modified to 0.995 for services provided during CY2015, and set at 0.99 for services provided beginning in CY2016 and beyond.

Sec. 202. Medicare Payment for Therapy Services.

Current Law

The BBA established two annual per beneficiary payment caps for all Medicare-covered outpatient therapy services furnished by non-hospital providers, one for physical therapy services and speech-language pathology services, the other for occupational therapy services. Initially set at \$1,500 by BBA to apply beginning in 1999, these caps were suspended from 2000-2005. With the application of the caps beginning with 2006, the DRA required the Secretary to implement an exceptions process throughout 2006 for services meeting specified criteria for medically necessary services. Subsequent legislation has extended the exceptions process and increased the caps each year since then.

The Middle Class Tax Relief & Job Creation Act of 2012 (MCTRJCA, P.L. 112-96) established, in addition to the caps, an annual threshold at \$3,700 to be applied separately for the two categories of therapy services effective October 1, 2012. Medical review was required for services furnished above the threshold. In addition, therapy services furnished in hospital outpatient departments were included in the caps for the first time. The ATRA extended the exceptions process through December 31, 2013, extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department (HOPD) and requires outpatient therapy services furnished in a Critical Access Hospital (CAH) to count towards the cap and threshold. ATRA also extended the medical review requirement for therapy services furnished January 1, 2013 through December 31, 2013.

MCTRJCA also directed the Secretary, in consultation with relevant stakeholders, to implement, a claims-based data strategy designed to collect data on patient function during the course of outpatient therapy services beginning January 1, 2013. The data will assist in reforming the Medicare payment system for outpatient therapy services.

Chairman's Mark

The therapy cap would be repealed upon enactment. The \$3,700 threshold would be extended for one year, through the end of 2014, after which it would be repealed. Beginning January 1, 2015, a new medical review program for outpatient therapy services would be established for therapy for therapy providers as defined below. The Secretary would identify the services for medical review, using appropriate factors, which could include the following:

- (1) Services furnished by a therapy provider whose pattern of billing is higher compared to peers.
- (2) Services furnished by a therapy provider who, in a prior period, has a high claims denial percentage or is least compliant with other applicable requirements under this title.
- (3) Services furnished by a therapy provider who is newly enrolled in the Medicare program.
- (4) Services furnished by a therapy provider who has questionable billing practices, such as billing medically unlikely units of services in a day.
- (5) Services furnished to treat a type of medical condition.
- (6) Services identified by use of the standardized data elements required to be reported.
- (7) Services furnished by a single therapy provider or a group that includes such providers.
- (8) Other services as determined appropriate by the Secretary.

The Secretary would use prior authorization medical review for the identified outpatient therapy services furnished to a beneficiary above certain thresholds established by the Secretary, such as a dollar threshold or by type of outpatient therapy service or setting.

The Secretary would end the application of prior authorization medical review if the provider has a low denial rate under prior authorization. The Secretary could subsequently reapply prior authorization medical review to the therapy provider if this were determined to be appropriate. The Secretary would, where practicable, provide for prior authorization medical review for multiple services at a single time, such as services in a therapy plan of care.

The Secretary could use pre-payment review or post-payment review for services that are not subject to prior authorization medical review, including those services falling below the established thresholds. So as to not interfere with an ongoing investigation, the Secretary could determine that medical review does not apply in the case where fraud may be involved. The Secretary would conduct the prior authorization medical review of outpatient therapy services using Medicare administrative contractors or other review contractors.

No Medicare payment would be made for outpatient therapy services subject to this review unless a prior authorization determination were made in advance that the services met the Medicare reasonable and necessary requirements. A therapy provider could submit the information necessary for medical review by fax, by mail, or by electronic means. As soon as practicable, but not later than 24 months after the date of enactment, the Secretary would have to make available the electronic means necessary to receive information.

The Secretary would make a prior authorization determination within ten business days of receipt of the necessary medical documentation or, otherwise, be deemed to have found the services to meet the applicable requirements for Medicare coverage. The Chairman's Mark would not preclude subsequent payment denial for an outpatient therapy service that had been affirmed by medical review but did not meet other applicable Medicare requirements.

For outpatient therapy services furnished on or after January 1, 2015, when payment may not be made due to medical review, the current law limiting beneficiary liability when Medicare claims are disallowed would apply in the same manner as a claims denial when a service is not reasonable and necessary.

The Secretary could implement this medical review program by interim final rule with comment period. Requirements under current law (U.S.C. Chapter 35 of Title 44) regarding coordination of federal information under the Paperwork Reduction Act would not apply to this medical review program.

For purposes of this subsection the following definitions would apply. The term 'outpatient therapy services' would mean therapy services for which Medicare payment is made under the physician fee schedule, under the fee schedule for outpatient therapy services and comprehensive outpatient rehabilitation services, and under the payment system for outpatient critical access hospital (CAH) services. The term 'therapy provider'

would mean a provider of services (as defined under current law section 1861(u) of the SSA) or a supplier (as defined under current law section 1861(d)) who furnishes outpatient therapy services.

To implement this subsection, the Secretary would provide for the transfer of \$35,000,000 from the SMI Trust Fund to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year, beginning with fiscal year 2014. These amounts would remain available until expended.

Beginning with 2017 and then every two years, the Secretary would have to determine and publicly report the improper payment rate for outpatient therapy services for a 12-month period. If the improper payment rate is 50 percent or less of the Medicare fee-for-service improper payment rate for the same period, the Secretary would have to reduce the amount of medical review conducted for a prospective year and return an appropriate portion of the funding provided for that year.

The Government Accountability Office (GAO) would conduct a study on the effectiveness of medical review of outpatient therapy. The study would include an analysis of aggregate data on the number of individuals, therapy providers, and claims subject to review; the number of reviews conducted; and the outcomes of such reviews. Not later than three years after the date of enactment, the GAO would submit a report to Congress including recommendations for such legislation and administrative action.

The Chairman's Mark would establish the collection of standardized data elements for outpatient therapy services. Not later than six months after enactment, the Secretary would post a draft list of standardized data elements on the CMS website. The standardized data elements would include information with respect to the following domains, as determined appropriate by the Secretary: (1) demographic information, (2) diagnosis, (3) severity, (4) affected body structures and functions, (5) limitations with activities of daily living and participation, (6) functional status, and (7) other domains determined to be appropriate by the Secretary.

The Secretary would accept comments from stakeholders for 60 days after the posting date of the draft standardized data elements. In seeking such comments, the Secretary would use one or more mechanisms to solicit input from stakeholders that could include use of open door forums, town hall meetings, requests for information, or other mechanisms as determined appropriate by the Secretary.

No later than 120 days after the end of the comment period, the Secretary would post an operational list of standardized data elements on the CMS website, taking into account such comments. Subsequent revisions to the operational list of standardized data elements would be made through rulemaking and could be based on experience and input from stakeholders. No later than 18 months after posting the operational list of standardized data elements, the Secretary would develop and implement a system, which may be a web portal, for therapy providers to report the standardized data elements for individuals

receiving outpatient therapy services. The Secretary would seek comments from stakeholders regarding the best way to report the standardized data elements.

The Secretary would specify the frequency of reporting standardized data elements and seek comments from stakeholders regarding the frequency of the reporting. Beginning on the operational date of the reporting system, no Medicare payment would be made for outpatient therapy services furnished to a beneficiary unless a therapy provider were to report the standardized data elements for the beneficiary.

No later than 18 months after the date the data reporting system is operational, the Secretary would submit a report to Congress on the design of a new payment system for outpatient therapy services. The report would include an analysis of the standardized data elements collected and other appropriate data and information. It would consider (1) appropriate adjustments to payment (such as case mix and outliers), (2) payments on an episode of care basis, and (3) reduced payment for multiple episodes. The Secretary would consult with stakeholders regarding design of such a new payment system.

To implement the data collection effort and develop the report on a new outpatient therapy payment system, the Secretary would provide for the transfer of \$7,000,000 from the SMI Trust Fund to the CMS Program Management Account for each fiscal year from 2014 through 2018. The amounts transferred under this subparagraph would remain available until expended.

Requirements under current law (U.S.C. Chapter 35 of Title 44) regarding coordination of federal information, including the Paperwork Reduction Act, would not apply to the specification of the standardized data elements and implementation of the reporting system. There would be no administrative or judicial review of the specification of standardized data elements required under this subsection or the reporting system. For purposes of the specification of standardized data elements and the implementation of the reporting system, the terms ‘outpatient therapy services’ and ‘therapy provider’ have the meaning given those terms for the new medical review program.

The current claims-based data collection strategy designed to assist in reforming the Medicare payment system for outpatient therapy services, which was mandated by the MCTRJCA, would sunset effective the date of implementation of the data collection effort established above.

The Chairman’s Mark would require that each request for payment, or bill submitted on or after January 1, 2015, by a therapy provider for an outpatient therapy service furnished by a therapy assistant include an indication that the service was furnished by a therapy assistant (in a form and manner specified by the Secretary).

Sec. 203. Medicare Ambulance Services.

Current Law

The MIPPA provided an increase of 2 percent for ground ambulance payments that originate in an urban area and 3 percent for ground ambulance payments that originate in a rural area from July 1, 2008 to January 1, 2010. Subsequent legislation has extended these increased ground ambulance payments until January 1, 2014.

Bonus payments for ground ambulance services that originate in qualified rural areas were established for services provided after July 1, 2004 and before January 1, 2010. Qualified rural areas (also referred to as “super rural”) are those where the ambulance transport originates in a rural area determined by the Secretary to be in the lowest 25th percentile in terms of population density of all rural county populations. The bonus payment is a 22.6 percent increase for ambulance services that originate in super rural areas. Subsequent legislation has extended the increased ambulance payments in low population density areas until December 31, 2013.

Chairman’s Mark

The Chairman’s Mark would extend the temporary payment increases for ground ambulance payments and the bonus payments for ground ambulance services that originate in qualified rural areas for five years until January 1, 2019.

Additionally, the Mark would require the Secretary to develop a data collection system for ambulance providers and suppliers in consultation with stakeholders. The data collection system for ambulance services would include cost, revenue, and utilization and other information to evaluate appropriate payment rates, the utilization of capital equipment and ambulance capacity, and the different types of ambulance services furnished in different geographic regions. No later than January 1, 2015, the Secretary would be required to specify the data collection methodology and to identify a sample of providers and suppliers required to submit such data. Beginning July 1, 2015, identified providers and suppliers who fail to submit such data would receive a 5 percent reduction in Medicare ambulance payments for a one-year period.

The Secretary would be permitted to revise the data collection system as appropriate, after consultation with providers and suppliers of ambulance services. Such consultation would include the use of requests for information and other appropriate mechanisms. In order to continue to evaluate the appropriateness of payment rates, ambulance providers and suppliers would be required to submit such information no less than once every three years. Requirements under current law (U.S.C. Chapter 35 of Title 44) regarding coordination of federal information, including the Paperwork Reduction Act, would not apply to the collection of this information. There would be no administrative or judicial review of the data collection system or those identified as required to submit such information. For purposes of developing this data collection system, \$1 million would be transferred from the SMI Trust Fund.

Sec. 204. Medicare Dependent Hospitals.

Current Law

The Omnibus Budget Reconciliation Act of 1989 (P.L.101-239) created a new Medicare Dependent Hospitals (MDHs) program that made small, rural hospitals eligible for additional payments. The MDH program lapsed in 1994 and was reinstated by the BBA. The program has been extended periodically and changed by subsequent legislation. The MDH special payment status expired on September 30, 2013.

MDHs are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. MDHs have no more than 100 beds and at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. Specifically, an MDH hospital will be paid the national prospective payment service (PPS) rate plus a percentage difference between that amount and a hospital-specific cost per discharge amount from a given year. Before October 1, 2006 an MDH received 50 percent of the difference between the base rate and its adjusted hospital-specific costs. Since October 1, 2006, an MDH has received 75 percent of the difference between the base rate and its adjusted hospital-specific costs.

Chairman's Mark

The Chairman's Mark permanently extends the MDH program and modifies additional provisions related to MDHs beginning October 1, 2013. The eligible MDH reimbursement would be the Inpatient Prospective Payment System (IPPS) rate plus 62.5 percent of the difference between the MDH's costs per discharge and the IPPS rate. No later than a year after enactment, the GAO would be required to issue a report on the payer mix and potential future payer mix of MDHs, characteristics of MDHs that meet the 60 percent requirement threshold based on FY1987 cost reports, whether or not FY1987 should continue as an eligible cost reporting period for the 60 percent requirement, and other items deemed appropriate.

Sec. 205. Low-Volume Hospitals.

Current Law

Under the Medicare IPPS, certain low-volume hospitals receive a higher payment amount to account for their higher costs per discharge in Fiscal Year 2012 and Fiscal Year 2013. The adjustment operates on a sliding scale with hospitals having fewer than 200 Medicare discharges receiving a 25 percent payment increase, decreasing on a sliding scale to 0 percent for hospitals with more than 1,600 Medicare discharges. These hospitals must be located more than 15 miles or more from another comparable hospital. This adjustment expired on September 30, 2013.

The low-volume adjustment is based on the concept that large hospitals benefit from certain economies of scale that are not available to small hospitals with limited discharges. The Medicare Payment Advisory Commission (MedPAC) has reported that this adjustment is not well targeted because hospitals may have a small number of Medicare patients while also treating a large number of non-Medicare patients. In MedPAC's view, Congress may wish to consider changing the low-volume formula to reflect total discharges rather than Medicare discharges.

Chairman's Mark

The Chairman's Mark would permanently modify the low-volume adjustment standards under the Medicare IPPS beginning on October 1, 2013. For FY2014 and subsequent fiscal years, the low-volume adjustment standards would be 20 percent for hospitals with 500 or fewer total discharges, decreasing on a sliding scale to 0 percent for hospitals with more than 2,500 total discharges.

Sec. 206. Medicare Special Needs Plans.

Current Law

Section 231 of the Medicare Prescription Drug, Improvement and Modernization Act of 2008 (MMA, P.L. 108-173) established a new type of Medicare Advantage (MA) coordinated care plan to focus on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized (I-SNPs), (2) dually eligible (D-SNPs), and/or (3) individuals with severe or disabling chronic conditions (C-SNPs). Fully Integrated Dual Eligible SNPs (FIDE-SNPs) are a subset of D-SNPs that must fully integrate Medicare and Medicaid benefits, including long-term care services and supports, and have a contract with the state Medicaid program among other requirements.

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including: state licensure as a risk-bearing entity; MA reporting requirements that are applicable depending on plan size; and Part D prescription drug benefit requirements. SNP payment procedures mirror CMS's procedures for MA plans. SNPs prepare and submit a bid like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and risk adjustment payment methodology.

Among other changes, the MIPPA required that all SNPs have evidenced-based models of care (MOC). An MA organization must design separate MOCs to meet the special needs of the target population for each SNP it offers. MOCs must have goals and objectives for the targeted population, a specialized provider network, use nationally-recognized clinical practice guidelines, conduct health risk assessments to identify the special needs of beneficiaries, and add services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

The ACA extended SNP authority through December 31, 2013 and temporarily extended authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service area. Other ACA changes applicable to SNPs included the following: 1) required all SNPs to comply with an approval process that will be based on CMS standards and executed by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012. NCQA rating is based on scores for each of eleven clinical and non-clinical elements in each SNPs MOC; 2) authorized CMS to pay a frailty adjustment payment to Fully Integrated Dual Eligible SNPs (FIDE-SNPs); 3) established new cost-sharing requirements for SNPs; and 4) required CMS to implement new quality-based payment procedures for all MA plans by 2012.

In addition, the ACA required the Secretary to establish the Federal Office of Coordinated Health Care (MMCO) within CMS to facilitate Medicare and Medicaid coordination within CMS for dual eligible beneficiaries.

The ATRA extended SNP authority through December 31, 2014, and also temporarily authorized SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas. Beginning January 1, 2015, SNP enrollment will not be restricted only to special needs individuals.

Chairman's Mark

The Chairman's Mark would permanently authorize I-SNPs, re-authorize D-SNPs through December 31, 2020, and re-authorize C-SNPs through December 31, 2017.

The Chairman's Mark would require the Secretary to establish by April 1, 2015 procedures that would unify the Medicare and Medicaid appeals procedures applicable to D-SNPs. In establishing unified Medicare-Medicaid appeals procedures, the Secretary would be required to solicit comments from states, plans, beneficiary representatives, and other relevant stakeholders. To the extent compatible with the process for unifying Medicare and Medicaid appeals procedures, the Secretary would ensure that the following requirements were included: 1) adoption of the most protective provisions for D-SNP enrollees under current law, including continuation of benefits under Medicaid pending timely filed appeals; 2) differences in Medicaid state plans are taken into account; and 3) be easily navigable by D-SNP enrollees. The unified procedures must also include: 1) a single notification of all applicable Medicare and Medicaid appeal rights; 2) appeals notices written in plain language and available in a language and format that is accessible to enrollees; 3) unified Medicare and Medicaid timeframes for internal (plan) and external (Medicare and Medicaid) such as the enrollee's filing of appeals, plan acknowledgement, and appeal resolution and notification of appeal decisions; and 4) mechanisms to allow D-SNP plans to track and resolve grievances. The Chairman's Mark would require that beginning January 1, 2016, D-SNP plan contracts would be required to use the unified Medicare-Medicaid appeals procedures.

The Chairman's Mark would require that beginning in January 1, 2018, most D-SNPs would be required to integrate all Medicare and Medicaid benefits and meet the requirements for a FIDE-SNP, including, to the extent current state law under the state's Medicaid plan permitted capitated payments for long-term care services or behavioral health services. If the Secretary determines that D-SNPs failed to meet contract requirements for full integration of all Medicare and Medicaid benefits for 2018 or 2019, the Secretary is authorized to impose one of the following sanctions: 1) reduce MA payments; 2) close enrollment to new plan enrollees; 3) apply MA sanctions, including civil money penalties and suspension; and 4) other reasonable actions as determined by the Secretary (other than the sanction to deem no longer meeting the D-SNP definition). Finally, the Chairman's Mark requires that in order to meet the definition of a D-SNP for 2020 and subsequent years, D-SNPs must fully integrate Medicare and Medicaid benefits and meet the current law definition of a FIDE-SNP.

D-SNPs that only enroll Medicare beneficiaries for whom the only Medicaid benefit to which the individuals are entitled is Medicare cost-sharing assistance would not be required to fully integrate Medicare and Medicaid benefits in their contracts effective January 1, 2018.

The Chairman's Mark would designate the MMCO as the dedicated CMS contact to assist states in addressing D-SNP Medicare-Medicaid misalignments. In this role, MMCO would be required to establish a uniform process for disseminating Medicare contract information to state Medicaid agencies as well as to D-SNPs. MMCO would also be required to establish basic resources for states that are interested in exploring D-SNPs as a platform for integrating Medicare-Medicaid services for dual eligible beneficiaries.

The Chairman's Mark would add the following requirements for C-SNP care management plans that would begin with contracts effective January 1, 2016: 1) the interdisciplinary provider team that C-SNPs are required to have would include providers with training in an applicable specialty and demonstrated expertise in treating individuals with the chronic conditions the C-SNP would target; 2) requirements developed by the Secretary to provide face-to-face encounters with the C-SNP's enrollees; 3) a requirement that MOC include the results of the initial assessment and each annual reassessment are addressed in the enrollee's required individualized care plan; 4) the Secretary would be required to ensure that as part of the annual MOC evaluation that whether or not the plan fulfilled the goals identified would be taken into account; and 5) the Secretary would be required to establish a minimum benchmark for each MOC element and to only approve a C-SNPs MOC if each element met those minimum benchmarks.

The Chairman's Mark would make changes to the SNP quality ratings and measurement and publication. Beginning with contracts effective January 1, 2016, the Secretary would be required to increase emphasis on SNPs' performance improvement or decline as follows when determining a plan's annual star ratings. Specifically, the Secretary of HHS would be required to ensure that at least 25 percent but not more than 33 percent of the annual star rating is based on the SNP's performance improvement or decline. The Secretary would be required to measure the SNP performance improvement or decline

based on the net change in the SNP plan's individual star rating measures. In order to ensure that plans are not punished in cases where it is impossible to improve, the Secretary would be authorized to appropriately adjust SNP plan improvement ratings when plans have achieved a 5-Star rating or the highest rating overall possible or for individual measures. This increased emphasis on improvement would not apply to SNPs with an overall star rating below a minimum threshold determined by the Secretary of HHS.

The Chairman's Mark would allow the Secretary to report and apply quality ratings of SNPs at the plan level instead of the contract level, as it is under current law. In requiring reporting and applying quality ratings at the plan level, the Secretary would be required to take into consideration the minimum enrollment that would be necessary to enable valid quality measurement at the plan level. In the instance the Secretary reports quality measures at the plan level, the quality measurement must include the Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. Also, if the Secretary uses the option to require quality reporting and the application of ratings at the plan level, then payment and other administrative actions linked to qualify measurement would be applied at the plan level.

The Chairman's Mark would require that GAO conduct a study to determine how the Secretary could change the MA SNP quality measurement system to allow an accurate comparison of the care quality provided by SNPs for individual plans as well as for SNPs overall, to the care quality delivered under Medicare FFS and other MA plans for similar populations. GAO would be required to submit the report on SNP quality compared to other Medicare delivery sources by July 1, 2016. GAO's report would be required to contain recommendations for legislative and administrative action as determined appropriate by GAO.

Sec. 207. Medicare Cost Contracts.

Current Law

Medicare cost contracts are contracts with private health plans where plan payment is based on the reasonable costs actually incurred to provide Medicare covered benefits to enrollees. Cost contracts were first authorized by the Social Security Amendments of 1972 (P.L. 92-603), as were contracts that paid private health plans a modified per capita (risk-based) monthly payment. The BBA prohibited the Secretary from extending or renewing cost contracts beyond December 31, 2002, while also transitioning the risk-based contracts to the new Medicare+Choice program, later to become the Medicare Advantage (MA) program. Seven subsequent pieces of legislation extended the Secretary's authority to enter into cost contracts, as follows:

- (1) The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) extended the authority through 2004.

- (2) The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) allowed cost contracts to expand their service areas if the request was submitted to the Secretary before September 1, 2003.
- (3) The MMA allowed cost contracts to be extended or renewed indefinitely. However, beginning in 2008, these contracts could not be extended or renewed for a service area that during the previous year had two or more MA regional plans or two or more MA local (formerly Medicare+Choice) plans.
- (4) The Medicare, Medicaid, and SCHIP Extensions Act of 2007 (MMSEA, P.L. 110-173) extended by one year – from January 1, 2008, to January 1, 2009 – the length of time a cost plan could continue to operate in an area previously served by two or more local MA plans or two or more regional MA plans.
- (5) The MIPPA extended by one year – from January 1, 2009, to January 1, 2010 – the length of time a cost plan could continue to operate in an area previously served by two or more local or two or more regional plans. To prohibit a cost plan from participating after January 1, 2010, the two or more plans in the service area were required to be offered by different organizations, and meet minimum enrollment requirements.
- (6) The ACA extended by three years – from January 1, 2010 to January 1, 2013 – the length of time a cost plan could continue to operate in an area previously served by two or more local or two or more regional plans that met minimum enrollment requirements.
- (7) The ATRA extended by one year – from January 1, 2013 to January 1, 2014 – the length of time a cost plan can continue to operate in an area previously served by two or more local or two or more regional plans that meet minimum enrollment requirements.

Under current law, Medicare cost contracts can be extended or renewed indefinitely, except that, under current authority, beginning on or after January 1, 2014, these contracts may not be extended or renewed in areas that during the entire previous year (2013) had two or more MA regional plans or two or more MA local plans offered by different organizations, with a minimum enrollment. These cost contracts will not be renewed at the end of 2014, based on minimum enrollment data for the 2013 contract year, and will cease to operate after 2014.

Chairman's Mark

Effective for plan year 2015, the Chairman's Mark would allow the Secretary to extend or renew cost contracts that had served an area where two or more local or regional MA plans with minimum enrollment had served in 2013, but would prohibit new enrollment into those cost contract plans for 2015.

Cost contract plans with restricted enrollment in 2015 would be able to either apply to convert to a new (MA) plan under Part C in 2016 (if they were to notify the Secretary of their intent to do so by a date specified by the Secretary), or have their contract terminated effective 2016.

The Secretary would be required to establish a process whereby the enrollees of the cost contract plans that were to convert to MA plans for 2016 would be automatically enrolled into a new MA plan. The automatic enrollment into the newly converted MA plans would also apply to the cost plan's enrollees with End Stage Renal Disease (ESRD). Cost plans that included a drug benefit would be required to retain drug coverage as part of their new MA plan. Similarly, cost plans that did not include a drug benefit would not be allowed to add one when applying to convert to MA plans. The MA monthly beneficiary premium for a converted plan would not be allowed to exceed the monthly premium under the previous cost contract by more than 10 percent. The converted plan would be required to provide benefits, premiums, and access to providers comparable to what was available under the cost plan the previous year. To ensure continuity of care, the converted MA plan would be required to maintain current providers and courses of treatment for enrollees at the time of enrollment for at least 90 days after enrollment. During this 90-day period, the converted plan would be required to pay non-contracted providers for items and services furnished to enrollees at amounts not less than amounts paid under original fee-for-service Medicare.

The Secretary would be required to identify the affected enrollees of plan conversions by no later than 30 days prior to the start of the annual coordinated election period (which begins on October 15th). Enrollees subject to the automatic enrollment would be able to change their enrollment during the annual, coordinated election period to a different MA plan or to Medicare fee-for-service and could also change their enrollment one additional time during a period starting after the last day of the annual, coordinated election period (December 7th) and ending on the last day of February of the following year.

Prior to the start of the annual coordinated election period, the Secretary would be required to send affected enrollees a notification of their automatic enrollment into the new MA plan and information about their options to make a different election during the annual coordinated election period and/or their additional special election period. The Secretary would also be required to provide affected enrollees with a description of the differences in benefits, cost-sharing, premiums, drug coverage, and provider networks between their former cost plan and the new MA plan.

The Secretary would be required to adjust the star quality rating used to set the maximum payment rate for MA plans so that the star rating for the newly converted MA plan for its first two plan years would be equal to the star rating assigned to the cost plan in the last year before it was converted to a new MA plan.

Sec. 208. Quality Measure Endorsement and Selection.

Current Law

Section 183 of the MIPPA (adding SSA section 1890) required the Secretary to have a contract with a consensus-based entity (e.g., National Quality Forum or NQF) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting; measure endorsement; measure maintenance;

convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities; and annual reporting to Congress. MIPPA section 183(d) appropriated \$10 million for each of the FY2009 through FY2012; section 609 of the ATRA extended this funding through FY2013.

Under current law, the Secretary is required to establish a pre-rulemaking process to select quality measures for use under Title XVIII. This process includes gathering multi-stakeholder input; making measures under consideration available to the public; transmission to, and consideration by, the Secretary of the input of multi-stakeholder groups; and the publication of the rationale for the use of any quality measure in the Federal Register; among others. The Secretary is required to establish a process for disseminating quality measures used; and to periodically review quality measures and determine whether to maintain the use of a measure or to phase it out. In addition, the consensus-based entity under the contract in SSA section 1890 (multi-stakeholder group convening and reporting duties) has additional duties. Through its Measure Applications Partnership (MAP), NQF has been convening multi-stakeholder groups to provide input into the selection of quality measures for use in the Medicare program; MAP has published two annual reports with recommendations for selection of quality measures (February 2012 and February 2013). HHS was appropriated \$20 million for each of FY2010 through FY2014 for these activities.

Chairman's Mark

Generally, the Chairman's Mark would modify the duties for the consensus-based entity with a contract under SSA section 1890; would add a new SSA section 1890A to create a second contract for a new entity to carry out duties related to the selection of quality measures; and would re-designate existing SSA section 1890A as SSA section 1890B and modify the duties for the Secretary under the new SSA section 1890B. In addition, the provision would extend funding for existing SSA sections 1890 and 1890A(a)-(d) for FY2014 and would combine funding for section 1890, new section 1890A, and the re-designated section 1890B (excluding the development of quality measures or public reporting on hospital-acquired conditions).

Specifically, the Chairman's Mark would re-designate existing SSA section 1890A as section 1890B, and would add a new section 1890A titled "Contract with an Entity Regarding Input on the Selection of Measures." An entity must meet the following requirements to qualify for becoming the new entity under section 1890A:

- (1) Be a private nonprofit entity;
- (2) Be governed by a board including representatives of health plans, health care providers and practitioners, health care consumers, purchasers, and employers;
- (3) Have at least 4 years of experience in working with measures; and
- (4) Have no membership fees or fees that are reasonable and adjusted based on the capacity of a potential member to pay. Membership fees would not be allowed to pose a barrier to the participation of individuals or groups

- with low or nominal resources in the entity's functions.
- (5) Not be a measure developer.

The Chairman's Mark would require that the contract be awarded beginning in FY2015; continue for a period of three years; and adhere to competitive bidding procedures as defined at 41 U.S.C. 403(5).

The Chairman's Mark would transfer the following duties currently under the SSA section 1890 consensus-based entity to the measure selection entity with the contract under the new SSA section 1890A: (1) priority setting (existing SSA section 1890(b)(1)); (2) convening of multi-stakeholder groups (existing SSA section 1890(b)(7)); and (3) transmission of multi-stakeholder input (existing SSA section 1890(b)(8)).

The Chairman's Mark would also create additional duties for the new entity. The entity would facilitate increased coordination and alignment between the public and private sectors with respect to quality and efficiency measures. The entity would have to conduct an ongoing analysis of gaps in endorsed quality and efficiency measures.

By March 1 of each year, the SSA section 1890A entity would have to issue a report on (1) the performance of its duties, (2) the recommendations of the entity's priority setting process, (3) the multi-stakeholder groups' input on the selection of quality and efficiency measures, (4) the findings of its gap analysis, and (5) any other items determined appropriate by the Secretary. Within 6 months of receiving this report, the Secretary would have to review the report and publish it in the Federal Register, together with any of the Secretary's comments on the report.

The Chairman's Mark would also modify the duties of the entity under SSA section 1890A related to convening multi-stakeholder groups. It would require the entity, to the extent feasible to make every effort to ensure its multi-stakeholders groups are balanced across stakeholders. The Chairman's Mark would also require the multi-stakeholder groups' input to include a detailed description of the rationale for each recommendation made. Such rationales could include (1) the expected impact of the measure on individuals, (2) the burden on providers and suppliers, (3) the expected influence over the behavior of providers and suppliers, (4) applicability of a measure for more than one setting or program, and (5) other areas determined in consultation with the Secretary. In providing the input, the entity could consider whether it is appropriate to provide separate recommendations with respect to measures for the internal use of a provider or supplier, quality reporting, public reporting, and payment provisions. The Chairman's Mark would also direct the multi-stakeholder group to provide input on the selection of quality and efficiency measures for use in other Social Security Act health care programs other than Medicare.

The Chairman's Mark would modify the dates by which the SSA section 1890A entity must transmit the multi-stakeholder group's input to the Secretary. For measures used under payment systems operating on a fiscal year basis, the entity would have to transmit the input by February 1. For all other measures received from the Secretary, the entity

would have to transmit the input by April 1. However, the Secretary could make available to the public a limited number of measures apart from the dates above. In turn, the entity with a contract under section 1890A would transmit to the Secretary the multi-stakeholder group's input on a timely basis.

The Chairman's Mark would modify the contracting process for the consensus-based entity with a contract under SSA section 1890. The Chairman's Mark would require the Secretary to rebid the contract for the consensus-based entity at least every three years, instead of every four years. It would strike the statutory reference to the National Quality Forum as an example of a possible consensus-based entity, and it would require that the entity not be a measure developer.

The Chairman's Mark would modify required duties for the consensus-based entity with a contract under SSA section 1890. It would strike the existing requirement that the entity review and endorse episode groupers. Because the Chairman's Mark would make priority setting, gap analysis, and convening multi-stakeholder groups the duties of the SSA section 1890A entity, the Chairman's Mark would eliminate the requirement that consensus-based entity annually report on these duties. The entity would also facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

The Chairman's Mark would modify the duties of the Secretary under new SSA section 1890B (existing SSA section 1890A). Specifically, the Chairman's Mark would modify the date by which the Secretary must make its list of measures available to the public and the SSA section 1890A entity for pre-rulemaking input. The applicable dates would be October 1 with respect to measures for use under payment systems that operate on a fiscal year basis, and January 1 with respect to all other quality and efficiency measures. However, the Secretary could make available to the public a limited number of measures apart from the dates above. The Chairman's Mark would also require the Secretary to consider the benefits of the alignment of measures between the public and private sector when periodically reviewing quality and efficiency measures.

The Secretary would also be required to publish a list of concordance rates for each type of provider or supplier. Each annual final rule would contain the concordance rate for the applicable type or types of providers and suppliers. The Secretary would also have to publish in the Federal Register the rationale for the use of any quality and efficiency measure that has not been recommended by the multi-stakeholder group.

The Chairman's Mark would require the Secretary to provide for the transfer of \$7 million for FY2014, from the Medicare Part A and B Trust Funds to the CMS Program Management Account, to carry out the activities in existing section 1890 and section 1890A(a)-(d). These amounts would be required to remain available until expended.

The provision would require the Secretary to provide for the transfer of \$25 million for each of fiscal years 2015 through 2017, from the Medicare Part A and B Trust Funds to

the CMS Program Management Account, to carry out section 1890; section 1890A; and section 1890B (excluding sections 1890B(e) and (f)).

The Chairman's Mark would specify that the changes above would be effective as of October 1, 2014, and that they would apply to contract periods under sections 1890 and 1890A that begin on or after October 1, 2014.

Sec. 209. Outreach and Assistance for Low-Income Programs.

Current Law

Section 119 of the MIPPA appropriated \$25 million for FY2008 and FY2009 for low-income Medicare beneficiary outreach and education activities through the following programs: State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA). Section 3306 of the ACA extended authority for the low-income outreach activities and appropriated \$45 million for these programs. The appropriations authorized by the ACA were available for obligation through FY2012. Section 610 of the ATRA extended these appropriations through FY2013 and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance activities: SHIPs, \$7.5 million; AAAs, \$7.5 million; ADRCs, \$5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5 million.

Outreach activities include counseling, education, enrollment assistance, health promotion, and other activities to help low-income Medicare beneficiaries understand their health insurance choices so they can make informed decisions. In addition to providing Medicare beneficiaries with counseling and education about their health insurance choices, outreach activities are intended to help low-income Medicare beneficiaries enroll in the Medicare Savings Program (MSP). MSP helps pay Medicare premiums and cost-sharing for beneficiaries who, due to their low income and assets, are eligible for both Medicare and Medicaid -- dual eligibles. MSP enrollment historically has been low, so outreach activities have been used to identify individuals who qualify for assistance.

Chairman's Mark

The Chairman's Mark would permanently appropriate current level funding (\$25 million each fiscal year) for low-income outreach and assistance activities. These funds would be allocated to the following programs in the same amounts as they are under current law: SHIPs, \$7.5 million; AAAs, \$7.5 million; ADRCs, \$5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5 million.

Subtitle B—Medicaid Other Extensions

Sec. 211. Qualifying Individual Program

Current Law

The BBA required states to pay Medicare Part B premiums for a new group of low-income Medicare beneficiaries – Qualifying Individuals (QIs) – with income between 120 percent and 135 percent of the Federal Poverty Limit (FPL). BBA also provided for Medicaid payment for QIs through an annual transfer from the SMI Trust Fund to the Treasury account that funds medical assistance payments to states (and in this case, the District of Columbia). Congress appropriated a total annual funding amount available for all states, and CMS allocated the funding to state Medicaid programs.

All eligible individuals are permitted to apply for QI assistance during a calendar year, but states are required to select individuals to receive QI financial assistance on a “first-come-first-served” basis up to the maximum that can be covered by their allocation. States must give preference in selecting individuals to receive QI assistance to individuals who received assistance in the last month of the previous year and who remain eligible. Individuals who receive QI assistance in a given month remain eligible for the remainder of that year, but their eligibility must be re-determined to continue to receive assistance in succeeding years. States receive 100 percent federal funding to pay QI’s Medicare Part B premiums up to the maximum number of beneficiaries whose Part B premiums can be paid from their federal allocation, but no additional matching beyond this annual allocation is available.

CMS developed a methodology to allocate to states the total fiscal year QI annual appropriation. The QI program has been reauthorized and funded a number of times since it was originally authorized. In December 2012, there were approximately 480,300 low-income Medicare beneficiaries who received financial assistance from state Medicaid programs to pay their Part B premiums.

Section 621 of the ATRA reauthorized the QI program through December 2013 and appropriated \$485 million for the second through the fourth quarters of FY2013 (January 1, 2013 – September 30, 2013) and \$300 million for the first quarter of FY2014 (October 1, 2013 through December 31, 2013).

Chairman’s Mark

The Chairman’s Mark would amend the SSA to authorize and fund the QI program by annually transferring funds from the SMI Trust Fund to the Treasury account that funds medical assistance payments to states for calendar years 2014 through 2018. The Mark also would remove restrictions on the number of beneficiaries who may receive QI assistance due to the capped allocation and the first-come first-served preference that states were required to use in determining which eligible beneficiaries would receive assistance.

Sec. 212. Transitional Medical Assistance.

Current Law

Medicaid requires states to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is known as transitional medical assistance (TMA). States must provide TMA to families losing eligibility for section 1931 of the Social Security Act (SSA) under two scenarios. First, states are permanently required to provide four months of TMA coverage to families who lose Medicaid eligibility under section 1931 due to increased child or spousal support collections. Families eligible for this four-month extension must have been receiving Medicaid under section 1931 in at least three of the preceding six months.

Second, under sections 1902(e)(1) and 1925, states are required to provide TMA to families losing section 1931 Medicaid eligibility for work-related reasons. States were originally required to provide four months of TMA to families losing eligibility due to an increase in hours of work or income from employment. However, the Family Support Act of 1988 (FSA, P.L. 100-485) expanded state TMA requirements under section 1925, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing section 1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time).

FSA originally authorized section 1925 to replace the four-month requirement in Section 1902(e)(1) through FY1998. However, the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA, P.L. 104-193) extended section 1925 through FY2001, and the provision has continued to exist under a series of short term extensions (most recently, through December 31, 2013).

If section 1925 were allowed to expire, states would still be required to provide four months of TMA to families who lose Medicaid eligibility due to an increase in earned income or hours of employment, but not to those who lose eligibility due to the loss of a time-limited earnings disregard. In addition, regardless of activity to extend section 1925, states would still be required to provide four months of TMA to families who lose section 1931 eligibility due to increased child or spousal support.

The ARRA created an additional work-related TMA option, allowing states to provide work-related TMA for a full 12-month period rather than two six-month periods. States may also waive the requirement that the family must have received Medicaid in at least three of six months preceding the month in which eligibility is lost.

Chairman's Mark

With regard to work-related TMA, the provision would extend the TMA sunset to December 31, 2018 for families in the 50 states and the District of Columbia who are no longer eligible for TANF because of increased hours of, or income from, employment or increased spousal support collections (under section 1902(e)(1)(A) and section 1925),

and/or because of an increase in income due to a time-limited income disregard (under section 1925 only). The provision would also permit states (i.e., the 50 states and the District of Columbia) that take up the ACA Medicaid expansion to seek CMS approval to opt out of the section 1925 work-related TMA-related requirements, and instead provide four months of TMA under the section 1902(e)(1) authority to certain families who have received aid under TANF and have earned income. The provision would also exempt states that opt out of section 1925 work-related TMA requirements from complying with the ACA child maintenance of effort provision which requires states to maintain their Medicaid programs with the same eligibility standards, methodologies and procedures for children up to age 19 until September 30, 2019.

The provision would modify the TMA-related requirements under Medicaid and Temporary Assistance for Needy Families (TANF) to consider only increases in income due to spousal support collections as a trigger for TMA eligibility. This change would align the income counting rules for TMA with the new Modified Adjusted Gross Income (MAGI) counting rules that will be used to determine Medicaid income eligibility for most Medicaid-eligible populations beginning January 1, 2014.

Sec. 213. Express Lane Eligibility.

Current Law

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) created a state plan option for "Express Lane" eligibility, through September 30, 2013, whereby states are permitted to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Supplemental Nutrition Assistance Program) for: (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, or (2) eligibility redeterminations. Authority for "Express Lane" eligibility determinations will sunset on September 30, 2014.

Chairman's Mark

The provision would extend the authority for "Express Lane" eligibility determinations until September 30, 2015.

Sec. 214. Pediatric Quality Measures.

Current Law

Section 401 of the CHIPRA required the Secretary to: identify and publish an initial core set of pediatric quality measures; submit a report to Congress on the quality of children's health care under Medicaid and CHIP; and to establish a Pediatric Quality Measures Program (PQMP) to identify pediatric measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set.

States are required to submit reports to the Secretary annually to include information about state-specific child health quality measures applied by the state. The Secretary is required to collect, analyze, and make publicly available the information reported by states annually. Section 401 also included funding for ten grants to states for demonstration projects to evaluate ideas to improve the quality of children's health care. Funding for these activities was appropriated in the amount of \$45 million for each of FY2009 through FY2013.

Chairman's Mark

The Mark would allow the development of pediatric quality measures established under CHIPRA section 401(b) to continue through September 30, 2015, by modifying the funding for adult quality measure development in SSA section 1139B to require the Secretary to spend \$15 million of the \$60 million appropriated on pediatric quality measure development under SSA section 1139A instead.

Sec. 215. Special Diabetes Programs.

Current Law

The BBA authorized two diabetes-related programs within the Public Health Service Act. The first, authorized in section 330B, provides funding for the National Institutes of Health to award grants for research into the prevention and cure of Type I diabetes. The second, authorized in section 330C, provides funding for the Indian Health Service (IHS) to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities. Since BBA, funding for this program has been appropriated in a series of laws. Funding for both these programs also increased from \$30 million per program in FY1998 to \$150 million per program from FY2004 to FY2014. Most recently, section 625 of the ATRA extended funding for these programs through FY2014.

Chairman's Mark

The Mark would extend funding for both programs through FY2019. Specifically, it would appropriate \$150 million for each program annually.

Subtitle C—Human Services Extensions

Sec. 221. Abstinence Education Grants.

Current Law

Section 912 of The PRWORA authorized abstinence education formula grants in SSA section 510. To receive these formula grants, states must request funding when applying for Maternal and Child Health Block Grant funds authorized in SSA section 501. Funds provided under SSA section 510 must be used exclusively for teaching abstinence from

sexual activity outside of marriage. PRWORA authorized and appropriated \$250 million (\$50 million for each of FY1998 through FY2002) for abstinence education. Subsequently, funding for this program was extended through June 30, 2009, by a series of legislation. Most recently, section 2954 of the ACA appropriated \$50 million for each of FY2010 through FY2014 for this program. In addition, \$5 million was added to be used to award competitive grants for FY2012 by the Consolidated Appropriations Act of 2012 (P.L. 112-74) and the Consolidated and Further Continuing Appropriations Act of 2013 (P.L. 113-6). FY2014 is the final year of funding for this program.

Chairman's Mark

The Chairman's Mark would extend authorization and funding for the SSA section 510 Abstinence Education program for five years, from FY2015 through FY2019, at \$50 million for each year.

Sec. 222. Personal Responsibility Education Program.

Current Law

Section 2953 of the ACA established the Personal Responsibility Education Program (PREP) in section 513 of the SSA. PREP is a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. The ACA also required the Secretary to award grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations. The ACA appropriated \$75 million appropriated for each of FY2010 through FY2014. The ACA required that \$10 million each year be reserved for the youth pregnancy prevention grants. The funds are available until expended. FY2014 is the final year of funding for this program.

Chairman's Mark

The Chairman's Mark would extend authorization and funding for SSA section 513 PREP for five years, from FY2015 through FY2019, at \$75 million for each year. The target population of the formula grant portion of the program would be expanded to include youth at risk for being a victim of sex trafficking or a victim of a severe form of trafficking in persons. The target population of the innovative strategies portion of the program would be expanded to include youth at risk for being a victim of sex trafficking or a victim of a severe form of trafficking in persons. The dates in the provision related to the mandatory use of unexpended allotments would be modified to conform to the five year extension of PREP. The base year for the maintenance-of-effort for non-federal funding would be changed from FY2009 to FY2014.

Sec. 223. Family-to-Family Health Information Centers.

Current Law

Section 6064 of the DRA established the Family-to-Family Health Information Centers program in SSA section 501(c). The program provides grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs. The DRA appropriated \$12 million for FY2007 through FY2009 for Family-to-Family Health Information Centers; the section 5507(b) of the ACA appropriated \$5 million for each of FY2009 through FY2012, with funding to remain available until expended. An additional \$5 million for FY2013 was included in section 624 of the ATRA. FY2013 was the final year of funding for this program.

Chairman's Mark

The Chairman's Mark would amend SSA section 501(c) to appropriate \$6 million for each of FY2014 through FY2018. The Mark would also add territories as eligible for the program by eliminating language in the subsection which defines "states" as the 50 states and the District of Columbia. This provision would be effective as if enacted on October 1, 2013.

Sec. 224. Health Workforce Demonstration Project for Low-Income Individuals.

Current Law

Section 5507(a) of the ACA requires the Secretary to establish a demonstration project under SSA section 2008(a) that award funds to states, Indian tribes, institutions of higher education, and local workforce investment boards for health profession opportunity grants (HPOG). These grants are designed to help provide low-income individuals—including individuals receiving assistance from the State Temporary Assistance for Needy Families (TANF) program—to obtain education and training in health care jobs that pay well and are in high demand. Funds are also used to provide financial aid and other supportive services. The ACA appropriated \$85 million for each of FY2010 through FY2014 to carry out this demonstration project and another demonstration project established by the ACA, under SSA section 2008(b), to develop training and certification programs for long-term care workers. FY2014 is the final year of funding for this program.

Chairman's Mark

The Chairman's Mark would amend SSA section 2008(c) to appropriate \$85 million for the HPOG demonstration under SSA section 2008(a), for each of FY2013 through FY2015.

Subtitle D—Other Provisions

Sec. 231. Commission on Patient Directed Health Care.

Current Law

No provision.

Chairman's Mark

The Chairman's Mark will create a Commission on Improving Patient Directed Health Care, which is a 15-member group charged with providing a forum for nationwide public debate in improving patient self-determination in health care decision-making; identifying strategies to ensure every American has the health care they want; and providing recommendations to Congress. The Commission, which includes the Secretary of HHS and 14 GAO-appointed members selected to represent a diverse range of perspectives and experience, will conduct hearings across the country to allow Americans to provide input on the associated issues. The Commission will issue a Report to the American People on Patient Directed Health Care that, among other things, summarizes what the Commission learned at its hearings and solicits comment from the public. Following close of the public comment period, the Commission will submit recommendations to the President and Congress. The Chairman's Mark makes \$3,000,000 available in each of fiscal years 2014 and 2015 for the Commission to conduct its work.

Sec. 232. Reducing Improper Medicare Payments.

Current Law

CMS relies on a variety of contractors to help administer the Medicare program, including Medicare administrative contractors (MACs) for fee-for-service (FFS) Medicare. Section 911 of the MMA required the Secretary of HHS to implement Medicare contracting reform, which was intended to improve Medicare's administrative services through the use of competition and performance incentives. MACs process Medicare claims, and serve as the primary operational contact between the FFS program, and Medicare's approximate 1.5 million health care providers and suppliers. MACs enroll providers and suppliers in Medicare and educate providers on Medicare billing requirements, as well as answering provider and beneficiary inquiries.

MACs are required to educate providers about the fundamentals of the program, policies and procedures, new initiatives, and other significant changes. MACs also identify potential improper payment issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing data, and the Recovery Audit Program data.

In addition to MACs, CMS also relies on other contractors that support program integrity activities such as Recovery Audit Contractors (RACs). Unlike other Medicare contractors, RACs are compensated on a contingency fee basis – their only payment is a percentage of the amount of each improper payment they identify, regardless of whether the claim was an overpayment or underpayment. RAC contingency fees vary depending on the contractor, the type of claim, and the part of Medicare. RACs must return contingency fees when overpayments are overturned on appeals filed by the Medicare providers and suppliers. Overpayments identified by RACs are recouped by MACs and the amount of recouped funds less contingency fees paid to RACs and expenses for administering the RAC program are returned to the Medicare Trust Funds. RAC overpayment decisions that are appealed by providers affect the overpayment amount identified by RACs and the amount returned to the Medicare Trust Funds. The Medicare FFS appeals process has five levels: 1) the MACs, 2) Qualified Independent Contractors (QICs), 3) an Administrative Law Judge, 4) the Medicare Appeals Council, and 5) a Federal Court.

Chairman's Mark

The Chairman's Mark would require the Secretary to implement the following three initiatives: an improper payment outreach and education program; enhanced RAC transparency, and a RAC demonstration project.

The Chairman's Mark would require MACs to implement an improper payment outreach and education (OE) program. Each MAC would be required to have an improper payment OE program to provide outreach, education, training, and technical assistance activities to providers and suppliers in their geographic service areas. The improper payment OE would be conducted through the following: emails and other electronic communications, webinars, telephone calls, in-person training, and other forms of communications the Secretary deems appropriate. The information that would be conveyed through the improper payment OE program would include all of the following: 1) a list of each provider's and supplier's most frequent and expensive payment errors over the last quarter; 2) specific instructions on how to correct or avoid these errors in the future; 3) notice of all new procedures that the Secretary has approved for RACs; 4) specific instructions to prevent future issues related to new RAC procedures approved by the Secretary; and 5) other information the Secretary determines would be appropriate.

MACs would be required to ensure that all providers and suppliers in their geographic area are invited to participate (either in person or online) in an annual improper payment error rate reduction training.

The MAC OE program also would be required to include annual error rate reduction training. This training would give priority to reduce the following Medicare improper payments that: have the highest rate of improper payment; have the greatest total dollar amount of improper payments; are due to clear misapplication or misinterpretation of Medicare policies; are clearly due to common and inadvertent clerical or administrative

errors; or are due to other error types the Secretary determined could be prevented by the error training rate reduction program.

To assist MACs in conducting the improper payment error reduction training program, the Secretary would be required to supply MACs on a quarterly basis with a complete list of improper payments identified by RACs for the providers and suppliers in the MACs region. The quarterly list of improper payments identified by RACs that the Secretary would be required to supply would include the following information: 1) the providers and suppliers that have the highest improper payment rates; 2) the providers and suppliers that have the greatest improper payment amounts; 3) the items and services furnished in each MAC's geographic region that have the highest improper payment error rates; 4) the items and services in each MAC's geographic region that are responsible for the greatest improper payment amounts; and 5) other information the Secretary determines would be helpful to MACs in conducting the improper payment error reduction training program.

In providing information to assist MACs in conducting the improper payment error reduction training, the Secretary would be required to transmit that information so that it would be easy for MACs to identify the improper payment issues where outreach, education, training, and technical assistance would be most effective. The Secretary would ensure that information supplied to MACs was in an electronic and easily searchable format as well as that it clearly displayed the name and address of the provider or supplier, the amount of improper payment, and any other information the Secretary determines would be appropriate.

The Secretary would be authorized to retain up to 25 percent of the amounts recovered by the RAC program to implement the MAC OE program and to implement corrective actions to help reduce Medicare's error rate. The OE program requirements would be effective beginning on January 1, 2015.

The Chairman's Mark would add to the reporting requirements of the annual RAC report to Congress that is required under current law. Specifically, the Chairman's Mark would require information on the results of appeals at each appeal level for the following RAC review types: 1) automated, 2) complex, 3) medical necessity, 4) Part A, 5) Part B, and 6) durable medical equipment.

The Chairman's Mark would require the Secretary to conduct a three-year Medicare demonstration project to better target RAC audits. The demonstration would begin January 1, 2015. The Secretary would be required to consider the following in determining the demonstration's geographic area: a region's total number of providers and suppliers, the diversity of the region's providers and supplier types, the region's improper payment rate variation among individual providers and suppliers, and a mix of urban and rural providers and suppliers.

In conducting the demonstration, the Secretary would be required to identify the following two groups of providers and suppliers: 1) providers with low improper payment error rates, and 2) providers with high improper payment error rates. To assign a

select group of providers and suppliers in the geographic region to one of these groups, the Secretary would be required to analyze the following as they relate to the total number and dollar amount of claims submitted: 1) the improper payment rates of individual providers of services and suppliers; 2) the amount of improper payments made to individual providers of services and suppliers 3) the frequency of errors made by the provider of services or supplier over time; and 4) other information determined appropriate by the Secretary.

Only a small proportion of the total number of providers and suppliers in the demonstration's geographic area would be assigned to either the low error rate or the high error rate group. Providers and suppliers with high, expensive, and frequent improper payment errors would be identified as high-error providers and suppliers. Providers and suppliers with few, inexpensive, and infrequent errors would be identified as low error rate providers and suppliers.

Under the demonstration the Secretary would be required to adjust the number of records that could be requested from providers and suppliers by RACs. The Secretary would be required to increase the maximum number of records that could be requested by RACs from providers and suppliers identified as having high error rates and decrease the maximum number of records that could be requested by RACs from providers and suppliers identified by composite scores as having low error rates.

The Secretary would have further authority under the demonstration to make additional adjustments to RAC requirements to offer incentives to reduce improper payment error rates for providers and suppliers assigned to either the low error rate group or the high error rate group. However, the Secretary would be prohibited from exempting any provider from being subject to RAC audits under the demonstration project.

The HHS Office of Inspector General (OIG) would be required to evaluate the RAC demonstration and submit a report to Congress within 12 months of completion of the RAC demonstration.

To implement the RAC incentive demonstration project, the Secretary would be authorized to transfer \$10 million to CMS's Program Management Account from the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds in a proportion to be determined by the Secretary. These funds would be available until expended. In addition, the Secretary would be authorized to transfer to the OIG \$245,000 from the HI and SMI Trust Funds in a proportion to be determined by the Secretary.