Modifications to the Chairman's Mark of
The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013

To modify Section 102: Repealing the Sustainable Growth Rate and improving Medicare payment for physicians

On page 7 of the Mark:

Strike (1) after "section1861(r)" in the third line of the second paragraph.

On Page 17, of the Mark in paragraph (2)(b)(ii):

Strike, "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 EHR technology (as defined under section 1848(o)(4) of the SSA); and".

Insert, "(1) uses certified EHR technology (as defined under section 1848(o)(4) of the SSA), (2) is paid based on quality measures comparable to the VBP quality performance category, and (3) bears more than nominal financial risk if aggregate expenditures exceeds expected aggregate expenditures".

On Page 18 of the Mark, in paragraph (3)(b)(ii):

Strike, "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 EHR technology (as defined under section 1848(o)(4) of the SSA); and"

Insert, "(1) uses certified EHR technology (as defined under section 1848(o)(4) of the SSA), (2) is paid based on quality measures comparable to the VBP quality performance category, and (3) bears more than nominal financial risk if aggregate expenditures exceeds expected aggregate expenditures".

To modify Section 102: Repealing the Sustainable Growth Rate and improving Medicare payment for physicians

On page 8 of the Mark:

Add "to patients and other providers" after "timely exchange of clinical information" in bullet 3c.

On Page 9 of the Mark:

Add “consisting of 10 or fewer professionals” after “circumstances of small practices” in line 2 of fourth full paragraph.

To correct a drafting error in Section 103: Priorities and funding for quality measure development.

On Page 25 of the Mark:

In the third line of the first paragraph, strike “2013” and replace with “2014.”

To modify Section 103: Priorities and funding for quality measure development.

Strike “measures of overuse of services” in line 14 of the first full paragraph and insert, “measures of appropriate use of services (including measures of overuse)”.

To modify Section 106: promoting evidence-based care

On page 32 of the Mark:

Add “only” after “November, 15, 2015” in the first sentence of the second paragraph.

Add “provider-led” after “other” in the first sentence of the second paragraph.

Add after the first sentence in the second paragraph, “The Secretary shall only choose appropriate use criteria developed or endorsed by national professional medical specialty societies.”

To modify Section 106: Promoting evidence-based care

On page 33 of the Mark:

Add “only provider-developed or endorsed” after “with the use of” in the first sentence of the fourth paragraph.

Add after the first sentence of the fourth paragraph, “Any additional adoption of appropriate use criteria for other Part B services would be required to replicate only the provider developed or endorsed criteria framework of advanced imaging appropriate use criteria.”

To modify Section 108: Expanding claims data availability to improve care.

On page 37 of the Mark:

Add “and retirees” after “providing health insurance to its employees” in line 8 of the third paragraph.

Add “and retirees” after “providing health insurance to its employees” in line 11 of the third paragraph.

To make a technical correction to the Chairman’s Mark Section 206: Medicare Special Needs Plans

On page 47 of the Mark:

To add after “to the extend current state law under the state’s Medicaid plan permitted capitated payments for long-term care services or behavioral health services,” the sentence: “However, for purposes of the integration requirements beginning in 2018, the definition of a FIDE-SNP does not include the requirement that the D-SNP’s enrollment have similar average levels of frailty as the Programs of All-Inclusive Care for the Elderly (PACE) program.”

To modify Section 206: Medicare Special Needs Plans

On page 48 of the Mark:

Replace, “below a minimum threshold as determined by the Secretary of HHS” with “of not more than 2.5 stars.”

To modify Section 208: Quality measure endorsement and selection

On page 52 of the Mark:

In the last paragraph, strike “used under payment systems operating on a fiscal year basis,” and replace with “received from the Secretary by October 1”.

On page 53 of the Mark:

In fifth line of the third full paragraph, strike “with respect to measures for use under payments systems that operate on a fiscal year basis,” also strike “with respect to all other quality and efficiency measures”.

On the seventh line of the third full paragraph, before “However, the Secretary” add “The Secretary would provide for an appropriate balance of the number of measures made available by each date.”

To correct a drafting error in heading of Subtitle B.

On page 55 of the Mark:

Add “and” between “Medicaid” and “Other Extensions”.

To correct a drafting error in Section 214: Pediatric quality measures.

On page 58 of the Mark:

Add “at least’ before “$15 million” in line four of the second paragraph.

Title I Amendments

To Accept Grassley-Rockefeller #15, as modified:

On Page 17 of the Mark, in paragraph (2)(b)(ii):

After “Tricare” insert, “,or title XIX in the case where no medical home or alternative payment model is available under such title)”.

After, “exceeds expected aggregate expenditures,” insert, “or is a title XIX medical home meeting criteria comparable to medical homes expanded under section 1115A(c);”

On Page 18 of the Mark, in paragraph (3)(b)(ii):

After “Tricare” insert, “,or title XIX in the case where no medical home or alternative payment model is available under such title)”.

After, “exceeds expected aggregate expenditures,” insert, “or is a title XIX medical home meeting criteria comparable to medical homes expanded under section 1115A(c);”

On Page 19 of the Mark, in the paragraph beginning, “To encourage development and testing of additional APM”:

Add, “and (4) models that focus primarily on Medicaid, working in conjunction with CMCS.”

To Accept Menendez #3, as modified

Add in the first full paragraph of page 14, “in medically underserved areas,” after “in health professional shortage areas.”

To Accept Thune-Wyden-Roberts-Rockefeller-Enzi-Stabenow #5,

In Section 102 of Title I, add between the fourth and fifth full paragraphs the following paragraph: “This mark would ensure that professionals who move into an APM are free to use telehealth technology to enhance patient outcomes and improve quality regardless of the statutory restrictions in section 1834(m). This would mean that accountable care organizations, bundled payments, medical homes, or any other models developed to be an APM could use telehealth technology not paid under section 1834(m).”

To Accept Cardin-Bennet-Brown Amendment #2:

Add the following paragraph after the last paragraph of **Title I, Section 104**:

The Secretary would conduct an education and outreach campaign to inform providers and seniors of the benefits of chronic care coordination and encourage participation by seniors with multiple chronic conditions. The Secretary would work through the HHS Office of Rural Health Policy and the CMS Office of Minority Health to encourage participation by underserved rural populations and racial and ethnic minority populations. The Secretary would report to Congress by December 31, 2017 on the representation of beneficiaries living in rural areas and of racial and ethnic minority populations in the Chronic Care Management program, identify any barriers to participation and make recommendations for increasing participation.

To Accept Bennet-Thune #5, as modified:

Add to Section 108: this amendment would allow a qualified entity to provide, via an alternative method, the same data that would be available via an enclave. To do so, the Secretary must certify that the method would be as secure as a data enclave. If another secure method is used, the Secretary should enforce additional protections of the data between qualified entities and its users, such as a data use agreement or monetary penalties.

To Accept Cornyn-Cardin Amendments #9 and #10:

The following language on page 15 is modified as shown; the new language has been underlined:

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, (2) provide recommendations for improving the program, (3) evaluate the impact of technical assistance funding on the ability of providers (especially physicians in rural areas or HPSAs, and physicians treating other underserved populations) to improve within the VBP or successfully transition to APMs, and (4) provide recommendations for maximizing use of these technical assistance funds.

The GAO would submit reports to Congress on October 1, 2019 and October 1, 2021 on the transition of physicians in rural areas and HPSAs and physicians treating other underserved populations to APMs. The studies shall make recommendations on changes that could be made to overcome barriers for rural providers and those in HPSAs to participate in APMs.

Title II Amendments

To Accept Wyden #5:

Add to **Title II Section 206** a requirement that the Secretary of Health and Human Services consider applying the unified Medicare and Medicaid appeals procedures to other types of SNPs in addition to D-SNPs.

To Accept Wyden-Grassley Amendment #6, with modifications:

Add a new Section 233: Improve and Modernize Medicaid Data Systems and Reporting.
The Mark requires CMS to implement a strategic plan to address redundancies and gaps in Medicaid data systems and reporting through improvement and modernization of computer and data systems. Areas for improvement shall include, but are not limited to: the reporting of encounter data by managed care plans, the timeliness and quality of enrollment and other data, consistency of data across sources, and information about state program policies. The Secretary shall report on the implementation status no later than one year after enactment.

To Accept Nelson-Grassley-Rockefeller-Enzi #4:

Add a new Section 234: Special Needs Trust Fairness

The Mark amends section 1917(d)(4)(A) of the SSA by inserting "the individual," after "for the benefit of such individual by".

To Accept Nelson-Rockefeller-Casey #5:

Add a new Section 235: Annual Medicaid DSH Report

The Mark requires the Secretary of Health and Human Services to report to Congress on an annual basis beginning on January 1, 2015. The annual Medicaid DSH Report would contain the following elements:

- Changes in the number of uninsured individuals as compared to 2013 and compared to Congressional Budget Office estimates used at the time of ACA enactment;
- The extent to which hospitals continue to incur uncompensated costs for Medicaid patients and the uninsured;
- The extent to which hospitals continue to provide charity care and incur bad debt associated with Medicaid, the State Children's Health Insurance Program, and state or local indigent care programs, as reported on Medicare hospital cost reports;
- In the first year, a methodology for estimating the amount of unpaid patient deductibles, copayments and coinsurance incurred by hospitals for patients enrolled in qualified health plans through a health insurance exchange, using existing data and minimizing the

administrative burden on hospitals to the extent possible. Subsequent reports would include data collected pursuant to this methodology;

- For each state, the difference between the aggregate amount of hospital uncompensated care costs and the state's DSH allotment;

- The extent to which there are certain vital hospital systems that are disproportionately experiencing high levels of uncompensated care, that have multiple other missions, such as a commitment to graduate medical education, the provision of tertiary and trauma care services, public health and essential community services and comprehensive, coordinated care; and

- Such other issues related to the determination of State DSH allotments under Medicaid as the Secretary of Health and Human Services determines appropriate.

Subsection D

To Accept Nelson-Grassley #2:

Add to **Title II Subtitle D** an expansion of the scope of Medicaid Fraud Control Units (MFCU) activities that are eligible FFP to include the costs of investigating and prosecuting allegations of abuse or neglect against Medicaid beneficiaries receiving services in non-institutional settings.

To Accept with Modification Menendez-Brown #1:

Add to **Title II, Subtitle D, Section 232** a requirement that the Centers for Medicare & Medicaid Services seek advice and consultation from hospitals, physicians and other expert stakeholders to determine appropriate criteria to account for medically necessary inpatient admissions that last less than 2 midnights.

To Accept with Modification Carper-Bennet-Enzi-Isakson-Thune-Nelson #1:

Amend Title II, Subsection D to add a section on Preventing and Reducing Medicare and Medicaid Expenditures to help maintain the solvency of the Medicare Trust Fund and help to moderate the growth in Medicaid expenditures, including the following provisions:

Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims.

Require that National Prescriber Identifiers be adopted by Centers for Medicare & Medicaid Services (CMS) as the only allowed prescriber identifier for the Medicare prescription drug program.

Require that Prescription Drug Plan (PDP) sponsors obtain valid prescriber identifiers on all pharmacy claims under Medicare Part D, and require that the identifiers be validated.

Reforming How CMS Tracks and Corrects the Vulnerabilities Identified by Recovery Audit Contractors.

The Department of Health and Human Services (HHS) shall address overpayment vulnerabilities identified by Recovery Audit Contractors (RACs) in a timely manner, by establishing a process for tracking the effectiveness of changes made to payment policies and procedures that address the vulnerabilities identified by RACs.

As part of previously established reporting requirements to the Congress, the HHS Secretary shall annually report on the types and financial cost of improper payment vulnerabilities identified by RACs, how the Secretary is addressing such improper payment vulnerabilities, and an assessment of the effectiveness of changes made to payment policies and procedures. HHS shall ensure that each report does not include information that would be sensitive or otherwise negatively impact program integrity.

Strengthening Medicaid Program Integrity Through Flexibility.

Allow program integrity funds within CMS to be spent for hiring federal staff, whereas current law restricts some program integrity funding only through contracting. This change would allow CMS to develop more in-house program integrity expertise, and avoid losing expertise when a contract is changed.

Access to National Directory of New Hires.

HHS shall grant access to National Database of New Hires to CMS and the HHS OIG (under current law this database, which is maintained by HHS, excludes access to both).

Improving the Sharing of Data between the Federal Government and State Medicaid Programs.

Requires HHS to establish a plan to encourage and facilitate the inclusion of States in the Medicare and Medicaid Data Match Program and revises the Medicare and Medicaid Data Match Program to improve the program by furthering the design, development, installation, or enhancement of an automated data system to collect, integrate, and access data for program integrity, oversight, and administration purposes.

Requires HHS to develop and implement a plan that allows each State agency access to relevant data on improper payments for health care items or services provided to dual eligible individuals.

To Accept Carper-Toomey-Bennet #2:

Add to **Title II, Subtitle D, Section 233** the ability for CMS or CMMI to allow the Programs of All-Inclusive Care for the Elderly (PACE) to participate in demonstration programs under Section 1115 Research & Demonstration Projects and the Center for Medicare and Medicaid Innovation (CMMI). The amendment would add section 1934 of the Social Security Act, except for 1934(b)(1)(A) and 1934(c)(5), to the list of sections of the Social Security Act CMMI is permitted to waive. The amendment would encourage the Secretary to provide, in a budget

neutral manner, increased operational flexibility to support PACE programs' ability to improve and innovate, and to reduce technical and administrative barriers that have hindered enrollment in PACE.

To Accept with modification Cardin-Grassley #5:

Add to **Title II, Subtitle D, Section 234** a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program conducted outside of CMMI, consisting of not more than five plans, aimed at preventing or delaying institutionalization and "spend-down" among the at-risk Medicare population. Medicare beneficiaries who are below 150% of the federal poverty level and who are unable to perform two or more activities of daily living would become eligible to receive community-based long-term services and supports that address their health needs and promote independent living. An independent third party would conduct an evaluation to determine if the program has reduced hospitalizations, re-hospitalizations and nursing facility stays, and prevented or delayed participating beneficiaries from spending down their assets and becoming eligible for Medicaid.

To Accept Grassley #16:

Add to **Title II, Subtitle D, Section 236** to allow the Inspector General of the Department of Health and Human Services to receive and retain three percent of all collections pursuant to civil debt collection actions related to false claims or frauds involving the Medicare program under title XVIII or the Medicaid program under title XIX. These funds would then be available for oversight and enforcement activities of the Inspector General in order to provide the resources to pursue its mission in fighting fraud, waste, and abuse.

.

To Accept Toomey-Carper #2, as modified:

Add a new section, **Title II, Subtitle D, Section 237**, that would require the GAO study on alignment of quality measures, in Section 102 of the Chairman's Mark, to include measures used by selected state Medicaid programs. The report would consider those measures that cut across the Medicare population and those under 65. The amendment directs GAO to focus on measures that make up the most significant component of the value-based performance incentive program.

To Accept Portman-Cardin-Stabenow-Casey Amendment #2:

Add a new section, **Title II, Subtitle D, Section 239**, that would require proof of state licensure to gain the right to submit a bid in a state. Only after this requirement is met would compliant bids be accepted.

Wyden-Crapo Amendment # 7 to the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013

Add a new section, **Title II, Subtitle D, Section 240**, by requiring CMS to disclose during the rulemaking process which safety criteria triggered the procedure exclusion and by what

threshold. This amendment would not preclude CMS from requiring certain evidence that a procedure does not have safety issues in order to be recognized for payment.

To Accept Roberts #4,

Add a new section, **Title II, Subtitle D, Section 241**, that would establish requirements for the issuance of implementing regulations for any section of the Act. HHS would be required to: (1) issue a notice of proposed rulemaking that includes the proposed regulation; (2) provide a period of not less than 60 calendar days for comments on the proposed regulation; and (3) publish the final regulation or take alternative action (such as withdrawing the rule or proposing a revised rule with a new comment period) on the proposed regulation, not more than 18 months following publication of the proposed rule and not less than 30 calendar days before the effective date of such final regulation.

To Accept Enzi-Carper #1:

Add a new section, **Title II, Subtitle D, Section 242** to amend Section 1861(dd)(3)(B) and Section 1814(a)(7)(A)(i)(I) of the Social Security Act to allow physician assistants to provide and manage hospice care services for Medicare beneficiaries. The amendment does not include the authority to order hospice care for Medicare beneficiaries.

To Accept Carper-Isackson-Rockefeller-Wyden-Cardin #3, as modified:

Add a new section, **Title II, Subtitle D, Section 243**, that would direct the HHS Secretary to contract with measure developers to create, and submit for endorsement by a consensus-based entity, a Medicare quality measure to ensure that the notice of documentation related to patient health information and care preferences are transferred with patients as they move to other care settings or return home. These Medicare quality measures would be reported by hospitals, nursing homes, and home health agencies as part of existing quality reporting programs.

To Accept Thune-Bennet-Enzi-Roberts #1, as modified:

Add a new section, **Title II, Subtitle D, Section 244,** this amendment would allow general supervision by a physician or non-physician practitioner at critical access hospitals for payment of therapeutic hospital outpatient services. This stemmed from confusion over the 2009 Medicare outpatient prospective payment system final rule where CMS issued a new policy regarding direct physician supervision of outpatient therapeutic services. Many health care organizations, particularly critical access hospitals, recognized the release of this rule as a burdensome and unnecessary new policy change, but CMS characterized the change as a "restatement and clarification" of existing policy in place since 2001.

Additionally, non-physician practitioners at critical access hospitals may directly supervise cardiac and pulmonary rehab. This fixes a technical problem that prohibits non-physician practitioners from directly supervising cardiac and pulmonary rehabilitation services.

To Accept Cantwell #2

Add a new section, **Title II, Subtitle D, Section 243** that expands Section 1395x of 42 U.S.C. §1395 to define the term "inpatient hospital services" as the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and **(3)(A)** such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements; and

(B) with respect to a hospital described in section 1886(d)(1)(B)(v) [42 USC§ 1395ww(d)(1)(B)(v)] and located in the same building as or on the same campus as another hospital, items and services included in subsections (1) and (2) above, furnished by or to the hospital described in section 1886(d)(1)(B)(v) [42 USC§ 1395ww(d)(1)(B)(v)] under arrangements.

To Accept Cantwell #4, with modification

Add on page 19, in between the fourth and fifth full paragraph a new paragraph that reads: "The Secretary shall propose to Congress a plan to integrate Medicare Advantage alternative payment models (APM) that take into account a budget neutral value-based modifier."