Section by Section Summary of
The SGR Repeal and Medicare Beneficiary
Access Improvement Act of 2013

Title I – Medicare Payment for Physicians' Services

Section 101. Short Title; Table of Contents.

Section 102. Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services. This section repeals the SGR to provide needed long-term stability to payments to physicians and other practitioners, referred to as "professionals." After a three-year period during which no changes are made to the current payment system, it establishes a streamlined and improved incentive payment program that consolidates the three existing incentive programs. This single incentive program, referred to as the Value-Based Performance Incentive Program (VBP), continues the focus on quality, resource use, and electronic health record (EHR) use with which physicians are familiar, but in a cohesive program that avoids redundancies. Further, this section provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs).

Stabilizing Fee Updates

The flawed SGR mechanism that updates payments is permanently repealed, averting a 23.7 percent SGR-induced cut scheduled for January 1, 2014, and 2013 rates will be maintained through 2023. In 2023 and subsequent years, professionals participating in APMs that meet certain criteria would receive annual updates of two percent, while all other professionals would receive annual updates of one percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress in 2016 and 2020 that assesses the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D. These reports recognize the critical role that professionals have in directing care and utilization by evaluating the their impact on total program spending, including under the VBP program.

Consolidating Current Law Programs into Single VBP

Payments to professionals will be adjusted based on performance on a single budget-neutral VBP starting in 2017. The VBP streamlines and improves on the three distinct current law incentive programs:

- The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures;
- The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and
- Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.

Sunset Current Law Incentive Program Payment implications

The payment implications associated with the current law incentive program penalties are sunset at the end of 2016, including the two percent penalty for failure to report PQRS quality measures and the three percent (growing up to five percent in 2019) penalty for failure to meet EHR MU requirements.

The penalties that would have been assessed would now remain in the physician payment system, significantly increasing total payments compared to the current law baseline.

Professionals to Whom VBP Applies

The VBP will apply to: physicians, physician assistants, nurse practitioners, clinical nurse specialists, and clinical registered nurse anesthetists beginning in 2017. It could apply to all others professionals paid under the physician fee schedule beginning in 2019, provided there are viable performance metrics available. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from an eligible APM(s) [or that meet certain requirements] will be excluded from the VBP.

VBP Assessment Categories

The VBP will assess the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.

- Quality measures used in PQRS will be used for the quality category. However, the Secretary is required to solicit recommended measures annually and fund professional organizations and others to develop additional measures. Measures used in qualified clinical data registries would be used to assess performance. These steps ensure development and use of measures that are supported by the professionals to which they apply.
- Metrics used in the current VBM program will be used for the resource use category. However, the methodology that CMS is currently developing to identify resources associated with specific care episodes would be enhanced through public input and an alternative process that directly engages professionals. The alternative mechanism entails professionals reporting their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode). This supplemental mechanism addresses concern that algorithms and rules fail to accurately link the cost of services to a professional.
- EHR Meaningful Use requirements, demonstrated by use of a certified system, continue to apply to receive credit in this category. To prevent duplicative reporting, professionals who report comparable quality measures through certified EHR systems are deemed to meet the meaningful use clinical quality measure component.
- Professionals will be assessed on their effort to engage in clinical practice improvement activities. Incorporation of this new component enables professionals who are already performing such activities to receive credit. It also encourages activities that facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas.

Amount Tied to Performance and Performance Score Determination

The funding available for VBP incentive payments will be equal to 4 percent of the total estimated spending in 2017; six percent in 2018; eight percent in 2019; and ten percent in 2020. Starting 2021, the funding pool could increase but is capped permanently at no greater than 12 percent. This phase-in approach, which reduces the amount of funding tied to incentive programs compared to current law in the initial VBP years, allows professionals more time to prepare.

The entire funding pool for a year is required to be paid out in that year. Professionals will receive a VBP payment reduction no greater than the size of the funding percentage amount for the year (*e.g.*, four percent in 2017); the maximum payment increase will be no greater than funding percentage

amount (*e.g*. four percent in 2017). While no professional is required to get the minimum or maximum, these parameters provide certainty as to the potential payment adjustment range.

Professionals will be assessed and receive payment adjustments based on a composite score determined by performance on the four categories. To incentivize upward movement, professionals would also receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score. Professionals will only be assessed on the categories that apply.

The Government Accountability Office (GAO) is required to evaluate the VBP and issue reports in 2018 and 2021, including an assessment of the provider types, practice sizes, practice geography, and provider patient mix that are receiving VBP payment increases and reductions.

Expanded Participation Options and Tools to Enable Success

VBP participation options will be established to reduce administrative burden and enable physicians to engage in a way that best fits their practice situation. These options include: use of EHRs and clinical quality data registries maintained by physician specialty organizations; and the option to be assessed as a group, as a "virtual" group, or with an affiliated hospital.

Technical assistance will be available, through contracts with appropriate entities (such as Quality Improvement Organizations) to help practices with ten or fewer professionals improve VBP performance or transition to APMs. Priority will be given to practices with low VBP scores and those in rural and underserved areas. Funding will be $25 million annually from 2014 to 2018.

Professionals will receive confidential feedback on performance in the quality and resource use categories on an at least quarterly basis, likely through a web-based portal. This system of timely and actionable feedback replaces other, less effective mechanisms in current law. The portal will allow professionals to report VBP information, as feasible and appropriate.

Encouraging Participation in APMs

Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component will receive a five percent bonus each year from 2017-2022. A patient-centered medical home APM would be exempted from the downside financial risk requirement if proven to work in the Medicare population. Two tracks would be available for professionals to qualify for the bonus. The first option will be based on receiving a significant percent of Medicare revenue through an APM; the second will be based on receiving a significant of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if Medicare APM options are unavailable in their area.

Professionals who meet these criteria will be excluded from the VBP assessment and most EHR meaningful use requirements.

The bonus payment encourages professionals to consider participation in tests of APMs, recognizes that practice changes are needed to facilitate such participation, and promotes the alignment of incentives across payers.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is

specifically encouraged to test APMs relevant to specialty professionals, professionals in small practices, and those that align with private and state-based payer initiatives.

Section 103. Priorities and Funding for Quality Measure Development.

Measure Development Plan

Gaps in quality measurement programs will be addressed to ensure meaningful measures on which to assess professionals and funding will be provided for measure development priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the VBP and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by February 1, 2015, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities, which could include physician organizations, to develop priority measures and encourage electronic specification of such measures.

Annual Report

By February 1, 2016, and annually thereafter, the Secretary is required to report on the progress made in developing quality measures. The report will include descriptions of the number of measures developed, including the name and type of each measure. The report will also include descriptions of measures under development, including an estimated timeline for completion of such measures, as well as quality areas being considered for future measure development. The Secretary is required to seek stakeholder input regarding gaps and prioritization of measure development.

Funding

Funding will be $15 million annually in 2014 to 2018 for professional quality measure development. The funding will remain available through fiscal year 2021.

Section 104. Encouraging Care Management for Individuals with Chronic Care Needs. In order to encourage the management of care for individuals with chronic conditions, at least one payment code for care management services will be established for professionals treating such individuals. Payment for such services will be made to professionals practicing in a patient-centered medical home or comparable specialty practice certified by an organization(s) recognized by the Secretary. In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule, and will not be tied to an annual wellness or other preventive physical examination.

Section 105. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule.

Collection of Information to Assist in Accurate Valuation of Services

The Secretary is permitted to collect information from professionals and other providers and suppliers to assist in accurate valuation of service-level payments under the fee schedule. Such information may include: practice expense inputs, time involved in furnishing services, cost and charge data, and other elements the Secretary believes can be used to improve the valuation of services. The information may be collected via such mechanisms as surveys, practice logs, facility records, electronic health records, etc. The Secretary may only use this information in valuing services through notice

and comment rulemaking. Starting in 2014, $2 million in annual funding is available to compensate professionals who submit the requested information.

Potentially Misvalued Codes

The list of criteria the Secretary can use to identify potentially misvalued services is expanded to, include codes: that account for a majority of spending under the physician fee schedule; with substantial changes in procedure time; for which there may be a change in the site of service or a significant difference in payment between sites of service; services that may have greater efficiencies when performed together; or with high practice expenses or high cost supplies.

The legislation sets an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018. If the target is met, that amount is redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.

Beginning with the 2015 physician fee schedule, total downward relative value unit (RVU) adjustments for a service of 20 percent or more (as compared to the previous year) will be phased-in over a two-year period.

The Secretary is provided authority to smooth RVUs within a group of services, and GAO is required to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on the valuation of physician services. The report is due no later than one year after enactment.

Section 106. Promoting Evidence-Based Care.

Selection of Appropriate Use Criteria

The Secretary is required to establish a program that promotes the use of appropriate use criteria (AUC) for advanced diagnostic imaging. In consultation with stakeholders, and no later than November 15, 2015, the Secretary will specify one or more AUC(s) from among those developed or endorsed by national professional medical specialty societies or other entities, taking into account whether such criteria: have stakeholder consensus; are evidence-based; and are in the public domain.

Selection of Qualified Clinical Decision Support (CDS) Mechanisms

In consultation with stakeholders, and no later than April 1, 2016, the Secretary will identify and publish a list of qualified CDS mechanisms, at least one of which must be free of charge, that could be used by ordering professionals to consult with applicable appropriate use criteria. Such mechanisms may be included in or independent from certified EHR technology and must: make available the applicable AUC(s) and supporting documentation; indicate the AUC(s) being used when more than one is available; determine the extent to which an imaging order follows the AUC(s); provide documentation to the ordering professional that such consultation occurred; be updated to reflect revisions to the AUC(s); and meet applicable privacy and security standards. The mechanism may be required to provide feedback to the ordering professional regarding that professional's aggregate adherence to applicable AUC(s).

Consultation with Qualified CDS Mechanisms

Beginning January 1, 2017, payment will only be made to the furnishing professional for an applicable advanced diagnostic imaging service if the claim for such service includes information: 1) showing that the ordering professional consulted with a qualified CDS mechanism; 2) as to whether the ordered service adheres to the applicable AUC(s); and 3) regarding the national provider identifier (NPI) of the ordering professional. The requirement to consult with AUC(s) does not apply to imaging services: ordered for an individual with an emergency medical condition as defined under EMTALA; paid under Part A; ordered by professionals for individuals attributed to a APM that meets certain criteria; or ordered by professionals who meet hardship criteria, such as lack of Internet access.

Prior Authorization

Beginning with 2017, and in consultation with stakeholders, the Secretary will identify ordering professionals with low adherence to applicable AUC(s) ("outliers") based on two years of data. Beginning January 1, 2020, outlier physicians shall be subject to prior authorization for applicable imaging services. The legislation provides CMS with $5 million in each of 2019, 2020, and 2021 to carry out the prior authorization program.

Based on the experience with the use of AUC(s) for imaging services, and after obtaining input from stakeholders through an Advanced Notice of Proposed Rulemaking, the Secretary may establish an AUC program for other Part B services. GAO is required to provide a report to Congress no later than 18 months after enactment of this legislation regarding other Part B services for which the use of clinical decision support mechanism would be appropriate, such as radiation therapy and clinical diagnostic laboratory services.

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

Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, in addition to the quality and resource use information that would be posted through the VBP, the Secretary is required to publish utilization and payment data for professionals on the Physician Compare website. Such information will include the number of services furnished and submitted charges and payments for such services and will be searchable by the eligible professional's name, provider type, specialty, location, and services furnished.

The website will indicate, where appropriate, that information may not be representative of the eligible professionals entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals will to have an opportunity to review and correct this information prior to its posting on the website.

Section 108 Expanding Claims Data Availability to Improve Care.

Qualified Entities

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities. In order to ensure data security, the claims data will only be accessible through a qualified data enclave (e.g., a web-based portal) and may not be extracted from the enclave. Any data or analyses must be de-identified, except for services furnished by the provider accessing the data enclave or receiving an analysis. QEs will be permitted to provide or sell non-public analyses to health insurers and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such

analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

QEs that provide or sell analyses or provide access to a data enclave shall provide an annual report to the Secretary that provides an accounting of: 1) the analyses provided or sold, including the number of analysis and purchasers, fees received, the topics and purposes; and 2) access to the data enclave, including fees received, the entities that accessed the enclave, and how such data were used. The claims data available to QEs is expanded to include Medicaid/CHIP data.

Qualified Clinical Data Registries

Consistent with relevant privacy and security laws, the Secretary is required to make data available, for a fee that covers the cost of preparing the data, to qualified clinical data registries to support quality improvement and patient safety activities. Such registries must obtain consent prior to publicly reporting any data or analysis based on such data that is not de-identified.

Title II – Extensions and Other Provisions

Subtitle A – Medicare Extensions

Section 201 Work Geographic Adjustment. Under current law, the Medicare 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. This provision permanently adjusts the physician work geographic adjustment floor from 1.0 to 0.99 over three years.

Section 202. Payment for Outpatient Therapy Services. Current law places annual per beneficiary payment limits of $1,900 for all outpatient therapy services provided by non-hospital providers, but includes an exceptions process for cases in which the provision of additional therapy services is determined to be medically necessary. This provision eliminates the cap and requires prior-authorization targeting certain high-therapy users.

Section 203. Ambulance Add-On Payments. Under current law, ground ambulance transports receive add-on to their base rate payments of 2% for urban providers, 3% for rural providers, and 22.6% for super-rural providers. This provision extends current law for five years and requires ambulances to provide CMS with certain information regarding cost and utilization.

Section 204. Extension of the Medicare-Dependent hospital (MDH) program. The Medicare Dependent Hospital (MDH) program provides enhanced reimbursement to support rural health infrastructure and to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to prospective payment, and the MDH designation is designed to reduce this risk. This provision permanently extends the designation and reduces the hospital specific payment amount from 75 percent to 62.5 percent.

Section 205. Extension of Medicare inpatient hospital payment adjustment for low-volume hospitals. Qualifying low-volume hospitals receive add-on payments based on the number of total discharges. To qualify, the hospital must have less than 2500 total discharges. The maximum payment adjustment is lowered from 25 percent to 20 percent.

Section 206. Extension for specialized Medicare Advantage plans for special needs individuals. Special Needs Plans (SNPs) are specific Medicare Advantage (MA) plans that are permitted to target and enroll particular types of beneficiaries, including beneficiaries who are institutionalized (I-SNPs), eligible for both Medicare and Medicaid (D-SNPs), and have a particular chronic disease (C-SNPs). Under current law, SNPs will not be permitted to enroll only these populations beginning January 1, 2015. This provision permanently authorizes I-SNPs, extends D-SNPs by six years, and extends C-SNPs by three years. The provision also requires D-SNPs to increase integration of Medicare and Medicaid services and makes improvements to C-SNPs' model of care.

Section 207. Extension of Medicare Reasonable Cost Contracts. This provision transitions Medicare Cost contracts with two or more Medicare Advantage coordinated care plans in the same service area to Medicare Advantage beginning in 2016.

Section 208. Quality Measure Endorsement and Selection. Under the Medicare Improvement for Patients and Providers Act of 2008, HHS entered into a five year contract with a consensus-based entity for certain activities relating to health care performance. This provision would create a new entity beginning in FY15 that would assume some of the consensus-based entity's responsibilities, specifically priority setting, gap analyses, and convening multi-stakeholder groups to provide pre-rulemaking input. Additionally, this provision would provide CMS with $7 million in funding for FY14 (in addition to the $20 million already appropriated under current law) and $25 million per year from FY15-17 to pay for the consensus-based entity, the new entity, and certain quality functions.

Section 209. Extension of funding outreach and assistance for low-income programs. This provision permanently extends the funding for State Health Insurance Counseling Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and The National Center for Benefits Outreach and Enrollment.

Subtitle B – Medicaid and Other Extensions

Section 211. Extension of the Qualifying Individual Program. The Qualifying Individual (QI) program allows Medicaid to pay the Medicare Part B premiums for low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty. Under current law, QI expires December 31, 2013. This provision extends the QI program until December 31, 2018.

Section 212. Extension of Transitional Medical Assistance. Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings. Under current law, some TMA benefits expire December 31, 2013. This provision extends those TMA benefits until December 31, 2018. The provision would allow states that expand to cover adults under section 1902(a)(10)(A)(i)(VIII) to opt out of section 1925 TMA, but all states must continue to provide section 1902(e) TMA.

Section 213. Extension of Medicaid and CHIP Express Lane option. The CHIP Reauthorization Act of 2009 created a new option that allows state Medicaid and CHIP offices to rely on data from other state offices, like SNAP and school lunch programs, in making eligibility determinations for children, called Express Lane Eligibility (ELE). The authority to use ELE expires on September 30, 2014. This provision would extend ELE authority through September 30, 2015.

Section 214. Extension of Pediatric Quality Measure Development. The CHIP Reauthorization Act of 2009 created a pediatric quality program that included pediatric quality measure development. Current funding will allow pediatric quality measure development to continue through fiscal year 2014. This provision requires the Secretary to spend $15 million originally allocated for adult quality measure development on pediatric measure development in order to allow work to continue through September 30, 2015.

Section 215. Extension of Special Diabetes Program for Type 1 diabetes and for Indians. The Special Diabetes Program (SDP) funds research for type I diabetes and supports diabetes treatment and prevention initiatives for American Indians and Alaska Natives. SDP expires at the end of fiscal year 2014, but early reauthorization is critical to the continuation of the existing research initiatives. This provision would extend the SDP for five years, through September 30, 2019.

Subtitle C- Human Services Extensions

Sec. 221. Abstinence-Only Education Grants. Under current law, this program provides funding for the exclusive purpose of teaching abstinence-only education classes and was authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Most recently, the ACA appropriated $50 million for each of FY2010 through FY2014 for this program. This provision would extend funding for an additional five years, from FY 2015 through FY 2019, at $50 million each year.

Sec. 222. Personal Responsibility Education Program. This program was established by the ACA to fund evidence-based programs to educate adolescents about abstinence, contraception, and adulthood. A total of $375 million was appropriated, at $75 million for each of FY2010 through FY2014. This provision would extend the current funding levels for an additional five years, from FY2015 through FY2019. This provision also expands eligible target populations in the formula grant portion and the innovative strategies portion of the program to include youth who are at-risk for being a victim of sex trafficking or a victim of a severe form of trafficking in persons.

Sec. 223. Family-to- Family Health Information Centers. This program was established under the Deficit Reduction Act of 2005 to provide health care information and resources to families of children with special health care needs. Funding was appropriated to provide $15 million for FY 2009 through FY2012, at $5 million each year. This provision expands funding for an additional five years, for each of FY2014 through FY2018, at $6 million per year. In addition, this provision adds territories as eligible for the program.

Sec. 224. Health Workforce Demonstration Project for Low-Income Individuals. This program aids low-income individuals in obtaining education and training in high-demand health care professions. The ACA appropriated $85 million in funding for each of FY2010 through FY2014. This provision extends funding for an additional two years of $85 million for each of FY2015 and FY2016.

Subtitle D – Other Provisions

Section 231. Commission on Patient Directed Health Care. 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.

Section 232. Reducing Improper Medicare Payments. Recovery Audit Contractors (RACs) audit payments to providers to ensure the correct amount was paid by Medicare. Overpayments or underpayments are identified and the proper adjustment is made. Medicare Administrative Contractors (MACs) are the main contractor responsible for paying providers and conducting some provider education. This provision creates a new provider education and outreach program funded by RAC recoveries, increases the information provided in CMS's annual RAC report and conducts a demonstration project to better target RAC audits.