THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

JULY 26, 2013

To: Energy and Commerce Committee Members

From: Majority Staff

Re: Full Committee Markup of H.R. 2810, Medicare Patient Access and Quality Improvement Act of 2013; and H.R. 2844, Federal Communications Commission Consolidated Reporting Act

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On Tuesday, July 30, 2013, at 4:00 p.m. in 2123 Rayburn House Office Building, the Energy and Commerce Committee will meet in an open markup session for opening statements on H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013" and H.R. 2844, the "Federal Communications Commission Consolidated Reporting Act of 2013." The Committee will reconvene on Wednesday, July 31, at 10:00 a.m. in 2123 Rayburn House Office Building in open markup session on the legislation.

In keeping with Chairman Upton's announced policy, Members must submit any amendments they may have two hours before they are offered during this markup. Members may submit amendments by email to Peter.Kielty@mail.house.gov. Any information with respect to an amendment's parliamentary standing (e.g., its germaneness) should be submitted at this time as well.

I. H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013"

A. Background

For over two years, the Energy and Commerce Committee, on a bipartisan basis, has examined Medicare's Sustainable Growth Rate (SGR) system of paying doctors. Based on this examination, it is clear that the current SGR, should it be allowed to work as designed, threatens access to care for millions of seniors in this country as well as the livelihood of medical providers who care for them. Therefore, repeal and replacement of the SGR is a necessary Medicare reform that will ensure the future viability of the program—but it must be done in a fiscally responsible way. Below provides background on the committee's work on the issue and H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013."

1. SGR During the 112th and 113th Congresses

On March 28, 2011, the Committee sent a bipartisan letter to approximately 50 physician groups and other stakeholders requesting suggestions for developing a long-term alternative to the SGR. The Committee received more than 30 responses. The responses varied from simply

proposing repeal of the SGR and providing for 10 years of stable payment updates to detailed and comprehensive payment and care delivery reforms.

In May 2011, the Committee held a hearing entitled "The Need to Move Beyond the SGR." This hearing explored the following issues: what is the role of newer payment/delivery systems now being evaluated; how do you measure quality; how do you pay for value, not volume; and how do you incentivize beneficiaries to make better choices?

In July 2012, the Committee held a hearing entitled "Using Innovation to Reform Medicare Physician Payment." This hearing examined possible options for how Medicare can use innovative ideas and payment/delivery models from the private sector to reform the current physician payment system.

At the end of the 112th Congress, Congress averted the 26.5 percent reduction in Medicare physician payment rates that was scheduled to go into effect on January 1, 2013. It accomplished this by extending current Medicare physician payment rates through December 31, 2013, at a cost of $25.2 billion.[1]

During the 113th Congress, on February 14, 2013, the Committee held a hearing entitled "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System." The hearing explored the following issues: the flaws of the current volume based physician payment system as described by Medicare Payment Advisory Committee Director Glenn Hackbarth; how to improve health through regional cooperatives and population based models; and how to measure quality and pay for value.

On May 28, 2013, the Committee released a discussion draft that contained various options of what SGR reform could take. The draft was designed to solicit feedback from stakeholders as well as Members of Congress.

On June 5, 2013, the Subcommittee held a hearing on the discussion draft. The Subcommittee heard testimony from health policy experts on how the discussion draft could be improved.

On June 28, the Committee released another discussion draft, which incorporated comments from stakeholders, including the physician community.

On July 23, the Health Subcommittee approved the Committee Print and an amendment offered by Mr. Burgess and Mr. Pallone by voice vote. On July 24, the amended Committee Print, as approved by the Subcommittee, was introduced by Mr. Burgess as H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013." H.R. 2810 had the following original cosponsors: Mr. Pallone; Chairman Upton; Mr. Waxman; Chairman Pitts; and Mr. Dingell.

2. Section-by-section

[1] Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline, available at: http://www.cbo.gov/publication/43502.

The SGR repeal and replace policy laid out in H.R. 2810 has two basic components: the Fee for Service Program (FFS) and the Payment Model Choice Program. Additionally, it contains policy language on Medicare data, care coordination, relative values, and standards of care. The following summarizes each section:

Section 1: Short title

This section provides the short title of "Medicare Patient Access and Quality Improvement Act of 2013."

Section 2: Reform of sustainable growth rate (SGR) and Medicare payment for physicians' services

Fee for Service

- Stabilizing Fee Updates (Phase I, 2014 - 2018)—The provision would repeal the SGR and replace it with a 5-year period of stable payments with annual inflationary baseline adjustments of 0.5%. This 5-year transition away from the SGR coupled with payment stability, is based on feedback from the medical community and other stakeholders. They expressed a need to have 3 to 5 years in order to develop and test quality measures and clinical practice improvement activities, which will be used for performance assessment during Phase II.

- Quality Update Incentive Program (QUIP) (Phase II, 2019)—The period of transition would end with the implementation of an enhanced Physician Quality Reporting System (PQRS), which would link payments to provider excellence in the delivery of high quality care. All providers who meet or exceed their specialty specific benchmark could receive a positive update of 1.5% per year.

Advancing Alternative Payment Models: Payment Model Choice Program

Eligible professionals at any time could choose to opt-out of the FFS program and participate in alternative payment models (APMs). These APMs would include, but would not be limited to, the following: Patient-Centered Medical Homes, specialty models, and bundles or episodes of care. Providers would submit proposals on an ongoing basis for innovative payment APMs through a newly developed, streamlined process that encourages high quality, high value healthcare.

Section 3: Expanding availability of Medicare Data

Medicare Data

Greater access to Medicare claims data would be made available to qualified entities to facilitate development of APMs and to facilitate quality improvement initiatives of qualified clinical data registries.

Section 4: Encouraging Care Coordination and Medical Homes

Care Coordination

Additional codes would be developed to promote better care coordination for patients with complex chronic care needs. These codes would apply to physicians who are certified as a medical home by achieving certain accreditation status.

Section 5: Miscellaneous

Solicitations, Recommendations, and Reports

The Centers for Medicare and Medicaid Services (CMS) would solicit recommendations from the medical community on episodes of care and payment bundles for high volume, high cost services. Not later than January 15, 2016, biannual progress reports on the QUIP and APM's would be submitted to Congress. GAO and MedPAC also would evaluate the QUIP and APM's and submit reports to Congress annually, corresponding with the performance years.

Relative Values

This policy would improve the accuracy of relative values under the Medicare Physician Fee Schedule. It would do so by establishing a mechanism for representative physician cohorts to report on data relating to service volume and time, accounting for differences in specialties, practitioner types, services, and patient populations.

Standards of Care

Under this provision, guidelines or standards developed, recognized, or implemented in conjunction with this legislation could not be construed to establish the standard of care in any medical malpractice or medical product liability claim.

II. H.R. 2844, the "Federal Communications Commission Consolidated Reporting Act"

Section 1: Short Title.

This section provides the short title of "Federal Communications Commission Consolidated Reporting Act."

Section 2. Adds section 14 to the Communications Act.

- New Section 14(a)—Communications Marketplace Report. Requires the FCC to publish and submit to Congress a communications marketplace report synched to the two-year Congressional cycle.

- New Section 14(b)—Contents. Requires the FCC to assess the state of competition in the communications marketplace, the state of deployment including the deployment of advanced telecommunications capability, and regulatory barriers to market entry and competitive expansion. Requires the FCC to identify the issues it plans to address over the next two years as a result of this assessment and to report on its progress on those issues previously identified.

- New Section 14(c)—Special Considerations. Requires the FCC to consider intermodal, facilities-based, and Internet-based competition and to compile a list of geographic areas that are not served by any provider of advanced telecommunications capability. Empowers the FCC to consider international and demographic data in making its assessments. Requires the FCC to consider market entry barriers for small businesses.

Section 3. Consolidates into a Communications Marketplace Report the ORBIT Act Report, the Satellite Competition Report, the International Broadband Data Report, the Status of Competition in the Market for the Delivery of Video Programming Report, the Report on Cable Industry Prices, Triennial Report Identifying and Eliminating Market Entry Barriers for Entrepreneurs and Other Small Businesses, the Section 706 Report, and the Report on the State of Competitive Market Conditions With Respect to Commercial Mobile Radio Services. Strikes from the Communications Act outdated or already repealed reports, including the Report on Competition between Wire Telephone and Wire Telegraph Providers, the 1997 Report on Spectrum Auctions, and several reports repealed by the Federal Reports Elimination and Sunset Act of 1995.

Section 4. Specifies that this Act does not alter the authority of the Commission in any way.

III. Staff Contacts

If you have any questions regarding H.R. 2810, please contact Robert Horne, Steve Ferrara, Katie Novaria, or Clay Alspach at (202) 225-2927.

If you have any questions regarding H.R. 2844, please contact David Redl or Kelsey Guyselman at (202) 225-2927.