

114TH CONGRESS
2D SESSION

S. _____

To amend title XVIII of the Social Security Act to implement Medicare payment policies designed to improve management of chronic disease, streamline care coordination, and improve quality outcomes without adding to the deficit.

IN THE SENATE OF THE UNITED STATES

Mr. HATCH (for himself, Mr. WYDEN, Mr. ISAKSON, and Mr. WARNER) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to implement Medicare payment policies designed to improve management of chronic disease, streamline care coordination, and improve quality outcomes without adding to the deficit.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Creating High-Quality Results and Outcomes Necessary
6 to Improve Chronic (CHRONIC) Care Act of 2016”.

1 (b) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—RECEIVING HIGH QUALITY CARE IN THE HOME

Sec. 101. Extending the Independence at Home Demonstration Program.

Sec. 102. Expanding access to home dialysis therapy.

TITLE II—ADVANCING TEAM-BASED CARE

Sec. 201. Allowing end-stage renal disease beneficiaries to choose a Medicare Advantage plan.

Sec. 202. Providing continued access to Medicare Advantage special needs plans for vulnerable populations.

TITLE III—EXPANDING INNOVATION AND TECHNOLOGY

Sec. 301. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees.

Sec. 302. Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees.

Sec. 303. Increasing convenience for Medicare Advantage enrollees through telehealth.

Sec. 304. Providing accountable care organizations the ability to expand the use of telehealth.

Sec. 305. Expanding the use of telehealth for individuals with stroke.

TITLE IV—IDENTIFYING THE CHRONICALLY ILL POPULATION

Sec. 401. Ensuring accurate payment for chronically ill individuals.

Sec. 402. Providing flexibility for beneficiaries to be part of an accountable care organization.

TITLE V—EMPOWERING INDIVIDUALS AND CAREGIVERS IN CARE DELIVERY

Sec. 501. Eliminating barriers to care coordination under accountable care organizations.

Sec. 502. GAO study and report on longitudinal comprehensive care planning services under Medicare part B.

TITLE VI—OTHER POLICIES TO IMPROVE CARE FOR THE CHRONICALLY ILL

Sec. 601. GAO study and report on improving medication synchronization.

Sec. 602. GAO study and report on impact of obesity drugs on patient health and spending.

TITLE VII—OFFSETS

Sec. 701. Offsets to be supplied.

1 **TITLE I—RECEIVING HIGH**
2 **QUALITY CARE IN THE HOME**

3 **SEC. 101. EXTENDING THE INDEPENDENCE AT HOME DEM-**
4 **ONSTRATION PROGRAM.**

5 Section 1866E of the Social Security Act (42 U.S.C.
6 1395cc-5) is amended—

7 (1) in subsection (e)—

8 (A) in paragraph (1), by striking “5-year
9 period” and inserting “7-year period”; and

10 (B) in paragraph (5), by striking “10,000”
11 and inserting “12,000”; and

12 (2) in subsection (i), by striking “second of 2”
13 and inserting “third of 3”.

14 **SEC. 102. EXPANDING ACCESS TO HOME DIALYSIS THER-**
15 **APY.**

16 (a) IN GENERAL.—Section 1881(b)(3) of the Social
17 Security Act (42 U.S.C. 1395rr(b)(3)) is amended—

18 (1) by redesignating subparagraphs (A) and
19 (B) as clauses (i) and (ii), respectively;

20 (2) in clause (ii), as redesignated by subpara-
21 graph (A), strike “on a comprehensive” and insert
22 “subject to subparagraph (B), on a comprehensive”;

23 (3) by striking “With respect to” and inserting
24 “(A) With respect to”; and

1 (4) by adding at the end the following new sub-
2 paragraph:

3 “(B) For purposes of subparagraph (A)(ii), an indi-
4 vidual determined to have end stage renal disease receiv-
5 ing home dialysis may choose to receive the monthly end
6 stage renal disease-related visits furnished on or after
7 January 1, 2018, via telehealth if the individual receives
8 a face-to-face visit, without the use of telehealth, at least
9 once every three consecutive months.”.

10 (b) ORIGINATING SITE REQUIREMENTS.—Section
11 1834(m) of the Social Security Act (42 U.S.C. 1395m(m))
12 is amended—

13 (1) in paragraph (4)(C)(ii), by adding at the
14 end the following new subclauses:

15 “(IX) A renal dialysis facility,
16 but only for purposes of section
17 1881(b)(3)(B).

18 “(X) The home of an individual,
19 but only for purposes of section
20 1881(b)(3)(B).”; and

21 (2) by adding at the end the following new
22 paragraph:

23 “(5) TREATMENT OF HOME DIALYSIS MONTHLY
24 ESRD-RELATED VISIT.—The geographic require-
25 ments described in paragraph (4)(C)(i) shall not

1 apply with respect to telehealth services furnished on
2 or after January 1, 2018, for purposes of section
3 1881(b)(3)(B), at an originating site described in
4 subclause (VI), (IX), or (X) of paragraph
5 (4)(C)(ii).”.

6 (c) CONFORMING AMENDMENT.—Section 1881(b)(1)
7 of the Social Security Act (42 U.S.C. 1395rr(b)(1)) is
8 amended by striking “paragraph (3)(A)” and inserting
9 “paragraph (3)(A)(i)”.

10 **TITLE II—ADVANCING TEAM-** 11 **BASED CARE**

12 **SEC. 201. ALLOWING END-STAGE RENAL DISEASE BENE-** 13 **FICIARIES TO CHOOSE A MEDICARE ADVAN-** 14 **TAGE PLAN.**

15 (a) REMOVING PROHIBITION.—

16 (1) IN GENERAL.—Section 1851(a)(3) of the
17 Social Security Act (42 U.S.C. 1395w–21(a)(3)) is
18 amended—

19 (A) by striking subparagraph (B); and

20 (B) by striking “ELIGIBLE INDIVIDUAL”
21 and all that follows through “In this title, sub-
22 ject to subparagraph (B),” and inserting “ELI-
23 GIBLE INDIVIDUAL.—In this title,”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 1852(b)(1) of the Social Secu-
2 rity Act (42 U.S.C. 1395w-22(b)(1)) is amend-
3 ed—

4 (i) by striking subparagraph (B); and
5 (ii) by striking “BENEFICIARIES” and
6 all that follows through “A
7 Medicare+Choice organization” and in-
8 serting “BENEFICIARIES.—A Medicare Ad-
9 vantage organization”.

10 (B) Section 1859(b)(6) of the Social Secu-
11 rity Act (42 U.S.C. 1395w-28(b)(6)) is amend-
12 ed, in the second sentence, by striking “may
13 waive” and all that follows through “subpara-
14 graph and”.

15 (3) EFFECTIVE DATE.—The amendments made
16 by this subsection shall apply with respect to plan
17 years beginning on or after January 1, 2021.

18 (b) EXCLUDING COSTS FOR KIDNEY ACQUISITIONS
19 FROM MA BENCHMARK.—Section 1853 of the Social Se-
20 curity Act (42 U.S.C. 1395w-23) is amended—

21 (1) in subsection (k)—

22 (A) in paragraph (1)—

23 (i) in the matter preceding subpara-
24 graph (A), by striking “paragraphs (2)

1 and (4)” and inserting “paragraphs (2),
2 (4), and (5)”;

3 (ii) in subparagraph (B)(i), by strik-
4 ing “paragraphs (2) and (4)” and insert-
5 ing “paragraphs (2), (4), and (5)”;

6 (B) by adding at the end the following new
7 paragraph:

8 “(5) EXCLUSION OF COSTS FOR KIDNEY ACQUI-
9 SITIONS FROM CAPITATION RATES.—After deter-
10 mining the applicable amount for an area for a year
11 under paragraph (1) (beginning with 2021), the Sec-
12 retary shall adjust such applicable amount to ex-
13 clude from such applicable amount the Secretary’s
14 estimate of the standardized costs for payments for
15 organ acquisitions for kidney transplants covered
16 under this title (including expenses covered under
17 section 1881(d)) in the area for the year.”;

18 (2) in subsection (n)(2)—

19 (A) in subparagraph (A)(i), by inserting
20 “and, for 2021 and subsequent years, the exclu-
21 sion of payments for organ acquisitions for kid-
22 ney transplants from the capitation rate as de-
23 scribed in subsection (k)(5)” before the semi-
24 colon at the end;

1 (B) in subparagraph (E), in the matter
2 preceding clause (i), by striking “subparagraph
3 (F)” and inserting “subparagraphs (F) and
4 (G)”; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(G) APPLICATION OF KIDNEY ACQUI-
8 TIONS ADJUSTMENT.—The base payment
9 amount specified in subparagraph (E) for a
10 year (beginning with 2021) shall be adjusted in
11 the same manner under paragraph (5) of sub-
12 section (k) as the applicable amount is adjusted
13 under such subsection.”.

14 (c) FFS COVERAGE OF KIDNEY ACQUISITIONS.—

15 (1) IN GENERAL.—Section 1852(a)(1)(B)(i) of
16 the Social Security Act (42 U.S.C. 1395w-
17 22(a)(1)(B)(i)) is amended by inserting “or coverage
18 for organ acquisitions for kidney transplants, includ-
19 ing as covered under section 1881(d)” after “hospice
20 care”.

21 (2) CONFORMING AMENDMENT.—Section
22 1851(i) of the Social Security Act (42 U.S.C.
23 1395w-21(i)) is amended by adding at the end the
24 following new paragraph:

1 “(3) FFS PAYMENT FOR EXPENSES FOR KID-
2 NEY ACQUISITIONS.—Paragraphs (1) and (2) shall
3 not apply with respect to expenses for organ acqui-
4 sitions for kidney transplants described in section
5 1852(a)(1)(B)(i).”.

6 (3) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply with respect to plan
8 years beginning on or after January 1, 2021.

9 (d) EVALUATION OF QUALITY.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services (in this subsection referred to as
12 the “Secretary”) shall conduct an evaluation of
13 whether the 5-star quality rating system, based on
14 the data collected under section 1852(e) of the So-
15 cial Security Act (42 U.S.C. 1395w–22(e)), should
16 include a quality measure specifically related to care
17 for enrollees in Medicare Advantage plans under
18 part C of title XVIII of such Act determined to have
19 end-stage renal disease.

20 (2) PUBLIC AVAILABILITY.—Not later than
21 April 1, 2020, the Secretary shall post on the Inter-
22 net website of the Centers for Medicare & Medicaid
23 Services the results of the evaluation under para-
24 graph (1).

1 (e) REPORT.—Not later than December 31, 2023, the
2 Secretary of Health and Human Services (in this sub-
3 section referred to as the “Secretary”) shall submit to
4 Congress a report on the impact of the provisions of, and
5 amendments made by, this section with respect to the fol-
6 lowing:

7 (1) Spending under—

8 (A) the original Medicare fee-for-service
9 program under parts A and B of title XVIII of
10 the Social Security Act; and

11 (B) the Medicare Advantage program
12 under part C of such title.

13 (2) The number of enrollees determined to have
14 end-stage renal disease—

15 (A) in the original Medicare fee-for-service
16 program; and

17 (B) in the Medicare Advantage program.

18 (3) The sufficiency of the amount of data under
19 the original Medicare fee-for-service program for in-
20 dividuals determined to have end-stage renal disease
21 for purposes of determining payment rates for end-
22 stage renal disease under the Medicare Advantage
23 program.

1 **SEC. 202. PROVIDING CONTINUED ACCESS TO MEDICARE**
2 **ADVANTAGE SPECIAL NEEDS PLANS FOR**
3 **VULNERABLE POPULATIONS.**

4 (a) **EXTENSION.**—Section 1859(f)(1) of the Social
5 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by
6 striking “and for periods before January 1, 2019”.

7 (b) **INCREASED INTEGRATION OF DUAL SNPS.**—

8 (1) **IN GENERAL.**—Section 1859(f) of the Social
9 Security Act (42 U.S.C. 1395w–28(f)) is amended—

10 (A) in paragraph (3), by adding at the end
11 the following new subparagraph:

12 “(F) The plan meets the requirements ap-
13 plicable under paragraph (8).”; and

14 (B) by adding at the end the following new
15 paragraph:

16 “(8) **INCREASED INTEGRATION OF DUAL**
17 **SNPS.**—

18 “(A) **DESIGNATED CONTACT.**—The Sec-
19 retary, acting through the Federal Coordinated
20 Health Care Office established under section
21 2602 of the Patient Protection and Affordable
22 Care Act, shall serve as a dedicated point of
23 contact for States to address misalignments
24 that arise with the integration of specialized
25 MA plans for special needs individuals de-
26 scribed in subsection (b)(6)(B)(ii) under this

1 paragraph and, consistent with such role,
2 shall—

3 “(i) establish a uniform process for
4 disseminating to State Medicaid agencies
5 information under this title impacting con-
6 tracts between such agencies and such
7 plans under this subsection; and

8 “(ii) establish basic resources for
9 States interested in exploring such plans
10 as a platform for integration, such as a
11 model contract or other tools to achieve
12 those goals.

13 “(B) UNIFIED GRIEVANCES AND APPEALS
14 PROCESS.—

15 “(i) IN GENERAL.—Not later than
16 April 1, 2018, the Secretary shall establish
17 procedures, to the extent feasible, unifying
18 grievances and appeals procedures under
19 sections 1852(f), 1852(g), 1902(a)(3),
20 1902(a)(5), and 1932(b)(4) for items and
21 services provided by specialized MA plans
22 for special needs individuals described in
23 subsection (b)(6)(B)(ii) under this title
24 and title XIX. The Secretary shall solicit
25 comment in developing such procedures

1 from States, plans, beneficiaries and their
2 representatives, and other relevant stake-
3 holders.

4 “(ii) PROCEDURES.—The procedures
5 established under clause (i) shall be in-
6 cluded in the plan contract under para-
7 graph (3)(D) and shall—

8 “(I) adopt the provisions for the
9 enrollee under current law that are
10 most protective for the enrollee and
11 are compatible with unified time-
12 frames and consolidated access to ex-
13 ternal review under an integrated
14 process;

15 “(II) take into account dif-
16 ferences in State plans under title
17 XIX to the extent necessary;

18 “(III) be easily navigable by an
19 enrollee; and

20 “(IV) include the elements de-
21 scribed in clause (iii), as applicable.

22 “(iii) ELEMENTS DESCRIBED.—Both
23 unified appeals and unified grievance pro-
24 cedures shall include, as applicable, the fol-
25 lowing elements described in this clause:

1 “(I) Single written notification of
2 all applicable grievances and appeal
3 rights under this title and title XIX.
4 For purposes of this subparagraph,
5 the Secretary may waive the require-
6 ments under section 1852(g)(1)(B)
7 when the specialized MA plan covers
8 items or services under this part or
9 under title XIX.

10 “(II) Single pathways for resolu-
11 tion of any grievance or appeal related
12 to a particular item or service pro-
13 vided by specialized MA plans for spe-
14 cial needs individuals described in
15 subsection (b)(6)(B)(ii) under this
16 title and title XIX.

17 “(III) Notices written in plain
18 language and available in a language
19 and format that is accessible to the
20 enrollee, including in non-English lan-
21 guages that are prevalent in the serv-
22 ice area of the specialized MA plan.

23 “(IV) Unified timeframes for
24 grievances and appeals processes,
25 such as an individual’s filing of a

1 grievance or appeal, a plan’s acknowl-
2 edgment and resolution of a grievance
3 or appeal, and notification of decisions
4 with respect to a grievance or appeal.

5 “(V) Requirements for how the
6 plan must process, track, and resolve
7 grievances and appeals, to ensure
8 beneficiaries are notified on a timely
9 basis of decisions that are made
10 throughout the grievance or appeals
11 process and are able to easily deter-
12 mine the status of a grievance or ap-
13 peal.

14 “(iv) CONTINUATION OF BENEFITS
15 PENDING APPEAL.—The unified procedures
16 under clause (i) shall, with respect to all
17 benefits under parts A and B and title
18 XIX subject to appeal under such proce-
19 dures, incorporate provisions under current
20 law and implementing regulations that pro-
21 vide continuation of benefits pending ap-
22 peal under this title and title XIX.

23 “(C) REQUIREMENT FOR UNIFIED GRIEV-
24 ANCES AND APPEALS.—For 2020 and subse-
25 quent years, the contract of a specialized MA

1 plan for special needs individuals described in
2 subsection (b)(6)(B)(ii) with a State Medicaid
3 agency under paragraph (3)(D) shall require
4 the use of unified grievances and appeals proce-
5 dures as described in subparagraph (B).

6 “(D) REQUIREMENT FOR FULL INTEGRA-
7 TION OF BEHAVIORAL HEALTH BENEFITS.—For
8 2021 and subsequent years, a specialized MA
9 plan for special needs individuals described in
10 subsection (b)(6)(B)(ii) shall integrate with
11 capitated contracts with States for all Medicaid
12 behavioral health benefits under this title and
13 title XIX.”.

14 (2) CONFORMING AMENDMENT TO RESPON-
15 SIBILITIES OF FEDERAL COORDINATED HEALTH
16 CARE OFFICE.—Section 2602(d) of the Patient Pro-
17 tection and Affordable Care Act (42 U.S.C.
18 1315b(d)) is amended by adding at the end the fol-
19 lowing new paragraphs:

20 “(6) To act as a designated contact for States
21 under subsection (f)(8)(A) of section 1859 of the So-
22 cial Security Act (42 U.S.C. 1395w–28) with respect
23 to the integration of specialized MA plans for special
24 needs individuals described in subsection
25 (b)(6)(B)(ii) of such section.

1 “(7) To be responsible for developing regula-
2 tions and guidance related to the implementation of
3 a unified grievance and appeals process as described
4 in subparagraphs (B) and (C) of section 1859(f)(8)
5 of the Social Security Act (42 U.S.C. 1395w-
6 28(f)(8)).”.

7 (c) IMPROVEMENTS TO SEVERE OR DISABLING
8 CHRONIC CONDITION SNPs.—

9 (1) CARE MANAGEMENT REQUIREMENTS.—Sec-
10 tion 1859(f)(5) of the Social Security Act (42
11 U.S.C. 1395w-28(f)(5)) is amended—

12 (A) by striking “ALL SNPS.—The require-
13 ments” and inserting “ALL SNPS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), the requirements”;

16 (B) by redesignating subparagraphs (A)
17 and (B) as clauses (i) and (ii), respectively, and
18 indenting appropriately;

19 (C) in clause (ii), as redesignated by sub-
20 paragraph (B), by redesignating clauses (i)
21 through (iii) as subclauses (I) through (III), re-
22 spectively, and indenting appropriately; and

23 (D) by adding at the end the following new
24 subparagraph:

1 “(B) IMPROVEMENTS TO CARE MANAGE-
2 MENT REQUIREMENTS FOR SEVERE OR DIS-
3 ABLING CHRONIC CONDITION SNPS.—For 2019
4 and subsequent years, in the case of a special-
5 ized MA plan for special needs individuals de-
6 scribed in subsection (b)(6)(B)(iii), the require-
7 ments described in this paragraph include the
8 following:

9 “(i) The interdisciplinary team under
10 subparagraph (A)(ii)(III) includes a team
11 of providers with demonstrated expertise,
12 including training in an applicable spe-
13 cialty, in treating individuals similar to the
14 targeted population of the plan.

15 “(ii) Requirements developed by the
16 Secretary to provide face-to-face encoun-
17 ters with individuals enrolled in the plan
18 not less frequently than on an annual
19 basis.

20 “(iii) As part of the model of care
21 under clause (i) of subparagraph (A), the
22 results of the initial assessment and an-
23 nual reassessment under clause (ii)(I) of
24 such subparagraph of each individual en-
25 rolled in the plan are addressed in the indi-

1 individual’s individualized care plan under
2 clause (ii)(II) of such subparagraph.

3 “(iv) As part of the annual evaluation
4 and approval of such model of care, the
5 Secretary shall take into account whether
6 the plan fulfilled the previous year’s goals
7 (as required under the model of care).

8 “(v) The Secretary shall establish a
9 minimum benchmark for each element of
10 the model of care of a plan. The Secretary
11 shall only approve a plan’s model of care
12 under this paragraph if each element of
13 the model of care meets the minimum
14 benchmark applicable under the preceding
15 sentence.”.

16 (2) REVISIONS TO THE DEFINITION OF A SE-
17 VERE OR DISABLING CHRONIC CONDITIONS SPECIAL-
18 IZED NEEDS INDIVIDUAL.—

19 (A) IN GENERAL.—Section
20 1859(b)(6)(B)(iii) of the Social Security Act
21 (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amend-
22 ed—

23 (i) by striking “who have” and insert-
24 ing “who—

1 “(I) before January 1, 2021,
2 have”;

3 (ii) in subclause (I), as added by
4 clause (i), by striking the period at the end
5 and inserting “; and”; and

6 (iii) by adding at the end the fol-
7 lowing new subclause:

8 “(II) on or after January 1,
9 2021, have one or more comorbid and
10 medically complex chronic conditions
11 that is life threatening or significantly
12 limits overall health or function, have
13 a high risk of hospitalization or other
14 adverse health outcomes, and require
15 intensive care coordination and that is
16 listed under subsection (f)(9)(A).”.

17 (B) PANEL OF CLINICAL ADVISORS.—Sec-
18 tion 1859(f) of the Social Security Act (42
19 U.S.C. 1395w–28(f)), as amended by subsection
20 (b), is amended by adding at the end the fol-
21 lowing new paragraph:

22 “(9) LIST OF CONDITIONS FOR CLARIFICATION
23 OF THE DEFINITION OF A SEVERE OR DISABLING
24 CHRONIC CONDITIONS SPECIALIZED NEEDS INDI-
25 VIDUAL.—

1 “(A) IN GENERAL.—Not later than De-
2 cember 31, 2019, the Secretary shall convene a
3 panel of clinical advisors to establish a list of
4 conditions that meet each of the following cri-
5 teria:

6 “(i) Conditions that meet the defini-
7 tion of a severe or disabling chronic condi-
8 tion under subsection (b)(6)(B)(iii) on or
9 after January 1, 2021.

10 “(ii) Conditions that—

11 “(I) require prescription drugs,
12 providers, and models of care that are
13 unique to the specific population of
14 enrollees in a specialized MA plan for
15 special needs individuals described in
16 such subsection on or after such date
17 and would not be needed by the gen-
18 eral population of beneficiaries under
19 this title; and

20 “(II) have a low prevalence in the
21 general population of beneficiaries
22 under this title or a disproportionately
23 high per-beneficiary cost under this
24 title.

1 In establishing such list, the panel shall take
2 into account the availability of varied benefits,
3 cost-sharing, and supplemental benefits under
4 the model described in paragraph (2) of section
5 1859(h), including the expansion under para-
6 graph (1) of such section.

7 “(B) UPDATING OF LIST.—Not later than
8 December 31, 2021, and every 5 years there-
9 after, the Secretary shall convene a panel of
10 clinical advisors to update the list under sub-
11 paragraph (A), taking into consideration the
12 criteria described in clauses (i) and (ii) of sub-
13 paragraph (A) and the availability of varied
14 benefits, cost-sharing, and supplemental bene-
15 fits under the model described in paragraph (2)
16 of section 1859(h), including the expansion
17 under paragraph (1) of such section.”.

18 (d) QUALITY MEASUREMENT AT THE PLAN LEVEL
19 FOR SNPs AND DETERMINATION OF FEASIBILITY OF
20 QUALITY MEASUREMENT AT THE PLAN LEVEL FOR ALL
21 MA PLANS.—Section 1853(o) of the Social Security Act
22 (42 U.S.C. 1395w–23(o)) is amended by adding at the end
23 the following new paragraphs:

24 “(6) QUALITY MEASUREMENT AT THE PLAN
25 LEVEL FOR SNPs.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the Secretary may require reporting
3 of data under section 1852(e) for, and apply
4 under this subsection, quality measures at the
5 plan level for specialized MA plans for special
6 needs individuals instead of at the contract
7 level.

8 “(B) CONSIDERATIONS.—Prior to applying
9 quality measurement at the plan level under
10 this paragraph, the Secretary shall—

11 “(i) take into consideration the min-
12 imum number of enrollees in a specialized
13 MA plan for special needs individuals in
14 order to determine if a statistically signifi-
15 cant or valid measurement of quality at
16 the plan level is possible under this para-
17 graph;

18 “(ii) if quality measures are reported
19 at the plan level, ensure that MA plans are
20 not required to provide duplicative infor-
21 mation; and

22 “(iii) ensure that such reporting does
23 not interfere with the collection of encoun-
24 ter data submitted by MA organizations or
25 the administration of any changes to the

1 program under this part as a result of the
2 collection of such data.

3 “(C) APPLICATION.—If the Secretary ap-
4 plies quality measurement at the plan level
5 under this paragraph, such quality measure-
6 ment may include Medicare Health Outcomes
7 Survey (HOS), Healthcare Effectiveness Data
8 and Information Set (HEDIS), Consumer As-
9 sessment of Healthcare Providers and Systems
10 (CAHPS) measures and quality measures under
11 part D.

12 “(7) DETERMINATION OF FEASIBILITY OF
13 QUALITY MEASUREMENT AT THE PLAN LEVEL FOR
14 ALL MA PLANS.—

15 “(A) DETERMINATION OF FEASIBILITY.—
16 The Secretary shall determine the feasibility of
17 requiring reporting of data under section
18 1852(e) for, and applying under this subsection,
19 quality measures at the plan level for all MA
20 plans under this part.

21 “(B) CONSIDERATION OF CHANGE.—After
22 making a determination under subparagraph
23 (A), the Secretary shall consider requiring such
24 reporting and applying such quality measures

1 at the plan level as described in such subpara-
2 graph.”.

3 (e) STUDIES AND REPORTS.—

4 (1) GAO STUDY AND REPORT ON STATE CON-
5 TRACTING WITH MANAGED CARE ENTITIES FOR
6 MEDICAID LONG TERM SERVICES AND SUPPORTS DE-
7 LIVERY AND WITH DUAL SNPS UNDER MEDICARE
8 ADVANTAGE.—

9 (A) STUDY.—The Comptroller General of
10 the United States (in this paragraph referred to
11 as the “Comptroller General”) shall conduct a
12 study on State contracting with managed care
13 entities with respect to the delivery of long-term
14 services and supports under the Medicaid pro-
15 gram under title XIX of the Social Security Act
16 (42 U.S.C. 1396 et seq.) and with specialized
17 MA plans for special needs individuals de-
18 scribed in subsection (b)(6)(B)(ii) of section
19 1859 of such Act (42 U.S.C. 1395w–28). Such
20 study shall include an analysis of the following:

21 (i) Each State in which the State
22 agency responsible for administering the
23 State plan under such title XIX has a con-
24 tract with such a specialized MA plan and
25 that delivers long term services and sup-

1 ports under the State plan under such title
2 XIX through a managed care program, in-
3 cluding the requirements under such State
4 plan with respect to long term services and
5 supports.

6 (ii) Types of such specialized MA
7 plans, which may include the following:

8 (I) A plan described in section
9 1853(a)(1)(B)(iv)(II) of such Act (42
10 U.S.C. 1395w-23(a)(1)(B)(iv)(II)).

11 (II) A plan that meets the re-
12 quirements described in subsection
13 (f)(3)(D) of such section 1859.

14 (III) A plan described in sub-
15 clause (II) that also meets additional
16 requirements established by the State.

17 (iii) Characteristics of individuals en-
18 rolled in such specialized MA plans.

19 (iv) The following with respect to
20 State programs for the delivery of long
21 term services and supports under such title
22 XIX through a managed care program:

23 (I) The population of individuals
24 eligible to receive such services and
25 supports.

1 (II) Whether all such services
2 and supports are provided on a
3 capitated basis or if any of such serv-
4 ices and supports are carved out and
5 provided through fee-for-service.

6 (III) Whether home and commu-
7 nity-based services under the State
8 plan are provided on a capitated
9 basis.

10 (B) REPORT.—Not later than January 1,
11 2019, the Comptroller General shall submit to
12 Congress a report containing the results of the
13 study conducted under subparagraph (A), to-
14 gether with recommendations for such legisla-
15 tion and administrative action as the Comp-
16 troller General determines appropriate.

17 (2) MACPAC STUDY AND REPORT ON STATE-
18 LEVEL INTEGRATION BETWEEN DUAL SNPS AND
19 MEDICAID.—

20 (A) STUDY.—The Medicaid and CHIP
21 Payment and Access Commission (in this para-
22 graph referred to as the “Commission”) shall
23 conduct a study on State-level integration be-
24 tween specialized MA plans for special needs in-
25 dividuals described in subsection (b)(6)(B)(ii) of

1 section 1859 of the Social Security Act (42
2 U.S.C. 1395w-28) and the Medicaid program
3 under title XIX of such Act (42 U.S.C. 1396 et
4 seq.). Such study shall include an analysis of
5 the following:

6 (i) The impact on spending under a
7 State plan under such title of—

8 (I) having such a specialized MA
9 plan available in the State; and

10 (II) delivering long term services
11 and supports under such plan through
12 a managed care program.

13 (ii) Spending under such title for
14 items and services furnished to such indi-
15 viduals on a fee-for-service basis as com-
16 pared to a capitated basis through a man-
17 aged care program.

18 (iii) The impact of having such a spe-
19 cialized MA plan available in the State on
20 waiting lists, such as whether individuals
21 placed on waiting lists for home and com-
22 munity-based services under the State plan
23 opted to enroll in such a specialized MA
24 plan.

1 (iv) Change in utilization from the
2 nursing home setting to home and commu-
3 nity-based services.

4 (v) Whether the availability of plans
5 described in section 1853(a)(1)(B)(iv)(II)
6 of such Act (42 U.S.C. 1395w-
7 23(a)(1)(B)(iv)(II)) had an impact on the
8 utilization of, and spending for, items and
9 services covered under such title XVIII,
10 such as whether access to home and com-
11 munity-based services kept enrollees in
12 such plans out of the hospital.

13 (B) REPORT.—Not later than January 1,
14 2019, the Commission shall submit to Congress
15 a report containing the results of the study con-
16 ducted under subparagraph (A), together with
17 recommendations for such legislation and ad-
18 ministrative action as the Commission deter-
19 mines appropriate.

1 **TITLE III—EXPANDING**
2 **INNOVATION AND TECHNOLOGY**
3 **SEC. 301. ADAPTING BENEFITS TO MEET THE NEEDS OF**
4 **CHRONICALLY ILL MEDICARE ADVANTAGE**
5 **ENROLLEES.**

6 Section 1859 of the Social Security Act (42 U.S.C.
7 1395w–28) is amended by adding at the end the following
8 new subsection:

9 “(h) NATIONAL TESTING OF MODEL FOR MEDICARE
10 ADVANTAGE VALUE-BASED INSURANCE DESIGN.—

11 “(1) IN GENERAL.—In implementing the model
12 described in paragraph (2) proposed to be tested
13 under section 1115A(b), the Secretary shall revise
14 the testing of the model under such section to cover,
15 effective not later than January 1, 2019, all States.

16 “(2) MODEL DESCRIBED.—The model described
17 in this paragraph is the testing of a model of Medi-
18 care Advantage value-based insurance design that
19 would allow Medicare Advantage plans the option to
20 propose and design benefit structures that vary ben-
21 efits, cost-sharing, and supplemental benefits offered
22 to enrollees with specific chronic diseases proposed
23 to be carried out in Oregon, Arizona, Texas, Iowa,
24 Michigan, Indiana, Tennessee, Alabama, Pennsyl-
25 vania, and Massachusetts.

1 “(3) TERMINATION AND MODIFICATION PROVI-
2 SION NOT APPLICABLE UNTIL JANUARY 1, 2022.—
3 The provisions of section 1115A(b)(3)(B) shall apply
4 to the model described in paragraph (2), including
5 such model as expanded under paragraph (1), begin-
6 ning January 1, 2022, but shall not apply to such
7 model, as so expanded, prior to such date.

8 “(4) FUNDING.—The Secretary shall allocate
9 funds made available under section 1115A(f)(1) to
10 design, implement, and evaluate the model described
11 in paragraph (2), as expanded under paragraph
12 (1).”.

13 **SEC. 302. EXPANDING SUPPLEMENTAL BENEFITS TO MEET**
14 **THE NEEDS OF CHRONICALLY ILL MEDICARE**
15 **ADVANTAGE ENROLLEES.**

16 (a) IN GENERAL.—Section 1852(a)(3) of the Social
17 Security Act (42 U.S.C. 1395w-22(a)(3)) is amended—

18 (1) in subparagraph (A), by striking “Each”
19 and inserting “Subject to subparagraph (D), each”;
20 and

21 (2) by adding at the end the following new sub-
22 paragraph:

23 “(D) EXPANDING SUPPLEMENTAL BENE-
24 FITS TO MEET THE NEEDS OF CHRONICALLY
25 ILL ENROLLEES.—

1 “(i) IN GENERAL.—For plan year
2 2019 and subsequent plan years, in addi-
3 tion to any supplemental health care bene-
4 fits otherwise provided under this para-
5 graph, an MA plan may provide supple-
6 mental benefits described in clause (ii) to
7 a chronically ill enrollee (as defined in
8 clause (iii)).

9 “(ii) SUPPLEMENTAL BENEFITS DE-
10 SCRIBED.—

11 “(I) IN GENERAL.—Supplemental
12 benefits described in this clause are
13 supplemental benefits that, with re-
14 spect to a chronically ill enrollee, have
15 a reasonable expectation of improving
16 or maintaining the health or overall
17 function of the chronically ill enrollee
18 and may not be limited to being pri-
19 marily health related benefits.

20 “(II) AUTHORITY TO WAIVE UNI-
21 FORMITY REQUIREMENTS.—The Sec-
22 retary may, only with respect to sup-
23 plemental benefits provided to a
24 chronically ill enrollee under this sub-
25 paragraph, waive the uniformity re-

1 requirement under subsection (d)(1)(A),
2 as determined appropriate by the Sec-
3 retary.

4 “(iii) CHRONICALLY ILL ENROLLEE
5 DEFINED.—In this subparagraph, the term
6 ‘chronically ill enrollee’ means an enrollee
7 in an MA plan that the Secretary deter-
8 mines—

9 “(I) has one or more comorbid
10 and medically complex chronic condi-
11 tions that is life threatening or signifi-
12 cantly limits the overall health or
13 function of the enrollee;

14 “(II) has a high risk of hos-
15 pitalization or other adverse health
16 outcomes; and

17 “(III) requires intensive care co-
18 ordination.”.

19 (b) GAO STUDY AND REPORT.—

20 (1) STUDY.—The Comptroller General of the
21 United States (in this subsection referred to as the
22 “Comptroller General”) shall conduct a study on
23 supplemental benefits provided to enrollees in Medi-
24 care Advantage plans under part C of title XVIII of

1 the Social Security Act. Such study shall include an
2 analysis of the following:

3 (A) The type of supplemental benefits pro-
4 vided to such enrollees, the total number of en-
5 rollees receiving each supplemental benefit, and
6 whether the supplemental benefit is covered by
7 the standard benchmark cost of the benefit or
8 with an additional premium.

9 (B) The frequency in which supplemental
10 benefits are utilized by such enrollees.

11 (C) The impact supplemental benefits have
12 on—

13 (i) the quality of care received by such
14 enrollees, including overall health and
15 function of the enrollees;

16 (ii) the utilization of items and serv-
17 ices for which benefits are available under
18 the original Medicare fee-for-service pro-
19 gram option under parts A and B of such
20 title XVIII by such enrollees; and

21 (iii) the amount of the bids submitted
22 by Medicare Advantage Organizations for
23 Medicare Advantage plans under such part
24 C.

1 (2) REPORT.—Not later than January 1, 2021,
2 the Comptroller General shall submit to Congress a
3 report containing the results of the study conducted
4 under paragraph (1), together with recommenda-
5 tions for such legislation and administrative action
6 as the Comptroller General determines appropriate.

7 **SEC. 303. INCREASING CONVENIENCE FOR MEDICARE AD-**
8 **VANTAGE ENROLLEES THROUGH TELE-**
9 **HEALTH.**

10 (a) IN GENERAL.—Section 1852 of the Social Secu-
11 rity Act (42 U.S.C. 1395w–22) is amended—

12 (1) in subsection (a)(1)(B)(i), by inserting “,
13 subject to subsection (m),” after “means”; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(m) PROVISION OF ADDITIONAL TELEHEALTH
17 BENEFITS.—

18 “(1) MA PLAN OPTION.—For plan year 2019
19 and subsequent plan years, subject to the require-
20 ments of paragraph (3), an MA plan may provide
21 additional telehealth benefits (as defined in para-
22 graph (2)) to individuals enrolled under this part.

23 “(2) ADDITIONAL TELEHEALTH BENEFITS DE-
24 FINED.—

1 “(A) IN GENERAL.—For purposes of this
2 subsection and section 1854:

3 “(i) DEFINITION.—The term ‘addi-
4 tional telehealth benefits’ means services—

5 “(I) for which benefits are avail-
6 able under part B, including services
7 for which payment is not made under
8 section 1834(m) due to the conditions
9 for payment under such section; and

10 “(II) that are identified as clini-
11 cally appropriate to furnish using elec-
12 tronic information and telecommuni-
13 cations technology when a physician
14 (as defined in section 1861(r)) or
15 practitioner (described in section
16 1842(b)(18)(C)) providing the service
17 is not at the same location as the plan
18 enrollee.

19 “(ii) EXCLUSION OF CAPITAL AND IN-
20 FRASTRUCTURE COSTS AND INVEST-
21 MENTS.—The term ‘additional telehealth
22 benefits’ does not include capital and infra-
23 structure costs and investments relating to
24 such benefits.

1 “(B) PUBLIC COMMENT.—Not later than
2 November 30, 2017, the Secretary shall solicit
3 comments on what types of telehealth services
4 currently offered to enrollees under this part
5 through supplemental health care benefits
6 should be considered to meet the definition of
7 additional telehealth benefits under this para-
8 graph.

9 “(3) REQUIREMENTS FOR ADDITIONAL TELE-
10 HEALTH BENEFITS.—The Secretary shall specify re-
11 quirements for the provision or furnishing of addi-
12 tional telehealth benefits, including with respect to
13 the following:

14 “(A) Physician or practitioner licensure
15 and other requirements such as specific train-
16 ing.

17 “(B) Factors necessary to ensure the co-
18 ordination of such benefits with items and serv-
19 ices furnished in-person.

20 “(C) Such other areas as determined by
21 the Secretary.

22 “(4) ENROLLEE CHOICE.—If an MA plan pro-
23 vides a service as an additional telehealth benefit (as
24 defined in paragraph (2)), an individual enrollee

1 shall have discretion as to whether to receive such
2 service as an additional telehealth benefit.

3 “(5) CONSTRUCTION REGARDING NETWORK AC-
4 CESS ADEQUACY.—Provision of additional telehealth
5 benefits under this subsection shall not be construed
6 as making such benefits available and accessible for
7 purposes of compliance with subsection (d).

8 “(6) TREATMENT UNDER MA.—For purposes of
9 this subsection and section 1854, additional tele-
10 health benefits shall be treated as if they were bene-
11 fits under the original Medicare fee-for-service pro-
12 gram option.

13 “(7) CONSTRUCTION.—Nothing in this sub-
14 section shall be construed as affecting the require-
15 ment under subsection (a)(1) that MA plans provide
16 enrollees with items and services (other than hospice
17 care) for which benefits are available under parts A
18 and B, including benefits available under section
19 1834(m).”.

20 (b) CLARIFICATION REGARDING INCLUSION IN BID
21 AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Se-
22 curity Act (42 U.S.C. 1395w-24(a)(6)(A)(ii)(I)) is
23 amended by inserting “, including, for plan year 2019 and
24 subsequent plan years, the provision of additional tele-

1 health benefits as described in section 1852(m)” before
2 the semicolon at the end.

3 **SEC. 304. PROVIDING ACCOUNTABLE CARE ORGANIZA-**
4 **TIONS THE ABILITY TO EXPAND THE USE OF**
5 **TELEHEALTH.**

6 (a) IN GENERAL.—Section 1899 of the Social Secu-
7 rity Act (42 U.S.C. 1395jjj) is amended by adding at the
8 end the following new subsection:

9 “(l) PROVIDING ACOs THE ABILITY TO EXPAND
10 THE USE OF TELEHEALTH SERVICES.—

11 “(1) IN GENERAL.—In the case of telehealth
12 services for which payment would otherwise be made
13 under this title furnished on or after January 1,
14 2019, for purposes of this subsection only, the fol-
15 lowing shall apply with respect to such services fur-
16 nished by a physician or practitioner participating in
17 an applicable ACO (as defined in paragraph (2)) to
18 a Medicare fee-for-service beneficiary assigned to the
19 applicable ACO:

20 “(A) INCLUSION OF HOME AS ORIGINATING
21 SITE.—Subject to paragraph (3), the home of a
22 beneficiary shall be treated as an originating
23 site described in section 1834(m)(4)(C)(ii).

24 “(B) NO APPLICATION OF GEOGRAPHIC
25 LIMITATION.—The geographic limitation under

1 section 1834(m)(4)(C)(i) shall not apply with
2 respect to an originating site described in sec-
3 tion 1834(m)(4)(C)(ii) (including the home of a
4 beneficiary under subparagraph (A)), subject to
5 State licensing requirements.

6 “(2) DEFINITIONS.—In this subsection:

7 “(A) APPLICABLE ACO.—The term ‘appli-
8 cable ACO’ means an ACO participating in a
9 model tested or expanded under section 1115A
10 or under this section—

11 “(i) that operates under a two-sided
12 model—

13 “(I) described in section
14 425.600(a) of title 42, Code of Fed-
15 eral Regulations; or

16 “(II) tested or expanded under
17 section 1115A; and

18 “(ii) for which Medicare fee-for-serv-
19 ice beneficiaries are assigned to the ACO
20 using a prospective assignment method, as
21 determined appropriate by the Secretary.

22 “(B) HOME.—The term ‘home’ means,
23 with respect to a Medicare fee-for-service bene-
24 ficiary, the place of residence used as the home
25 of the beneficiary.

1 “(3) TELEHEALTH SERVICES RECEIVED IN THE
2 HOME.—In the case of telehealth services described
3 in paragraph (1) where the home of a Medicare fee-
4 for-service beneficiary is the originating site, the fol-
5 lowing shall apply:

6 “(A) NO FACILITY FEE.—There shall be
7 no facility fee paid to the originating site under
8 section 1834(m)(2)(B).

9 “(B) EXCLUSION OF CERTAIN SERVICES.—
10 No payment may be made for such services that
11 are inappropriate to furnish in the home setting
12 such as services that are typically furnished in
13 inpatient settings such as a hospital.”.

14 (b) STUDY AND REPORT.—

15 (1) STUDY.—

16 (A) IN GENERAL.—The Secretary of
17 Health and Human Services (in this subsection
18 referred to as the “Secretary”) shall conduct a
19 study on the implementation of section 1899(l)
20 of the Social Security Act, as added by sub-
21 section (a). Such study shall include an analysis
22 of the utilization of, and expenditures for, tele-
23 health services under such section.

24 (B) COLLECTION OF DATA.—The Sec-
25 retary may collect such data as the Secretary

1 determines necessary to carry out the study
2 under this paragraph.

3 (2) REPORT.—Not later than January 1, 2025,
4 the Secretary shall submit to Congress a report con-
5 taining the results of the study conducted under
6 paragraph (1), together with recommendations for
7 such legislation and administrative action as the
8 Secretary determines appropriate.

9 **SEC. 305. EXPANDING THE USE OF TELEHEALTH FOR INDI-**
10 **VIDUALS WITH STROKE.**

11 Section 1834(m) of the Social Security Act (42
12 U.S.C. 1395m(m)), as amended by section 102(b)(2), is
13 amended by adding at the end the following new para-
14 graph:

15 “(6) TREATMENT OF STROKE TELEHEALTH
16 SERVICES.—

17 “(A) WAIVER OF ORIGINATING SITE RE-
18 QUIREMENTS.—The requirements described in
19 paragraph (4)(C) shall not apply with respect
20 to telehealth services furnished on or after Jan-
21 uary 1, 2018, related to the evaluation of an
22 acute stroke, as determined by the Secretary.

23 “(B) NO ORIGINATING FACILITY FEE.—
24 The Secretary shall not pay an originating site

1 facility fee (as described in paragraph (2)(B))
2 with respect to such telehealth services.”.

3 **TITLE IV—IDENTIFYING THE**
4 **CHRONICALLY ILL POPULATION**

5 **SEC. 401. ENSURING ACCURATE PAYMENT FOR CHRON-**
6 **ICALLY ILL INDIVIDUALS.**

7 (a) Section 1853(a)(1) of the Social Security Act (42
8 U.S.C. 1395w-23(a)(1)) is amended—

9 (1) in subparagraph (C)(i), by striking “The
10 Secretary” and inserting “Subject to subparagraph
11 (I), the Secretary”; and

12 (2) by adding at the end the following new sub-
13 paragraph:

14 “(I) IMPROVEMENTS TO RISK ADJUSTMENT
15 FOR 2019 AND SUBSEQUENT YEARS.—

16 “(i) IN GENERAL.—In order to deter-
17 mine the appropriate adjustment for health
18 status under subparagraph (C)(i), the fol-
19 lowing shall apply:

20 “(I) TAKING INTO ACCOUNT
21 TOTAL NUMBER OF DISEASES OR CON-
22 DITIONS.—The Secretary shall take
23 into account the total number of dis-
24 eases or conditions of an individual
25 enrolled in an MA plan. The Secretary

1 shall make an additional adjustment
2 under such subparagraph as the num-
3 ber of diseases or conditions of an in-
4 dividual increases.

5 “(II) USING AT LEAST 2 YEARS
6 OF DIAGNOSTIC DATA.—The Secretary
7 shall use at least 2 years of diagnosis
8 data.

9 “(III) PROVIDING SEPARATE AD-
10 JUSTMENTS FOR DUAL ELIGIBLE IN-
11 DIVIDUALS.—With respect to individ-
12 uals who are dually eligible for bene-
13 fits under this title and title XIX, the
14 Secretary shall make separate adjust-
15 ments for each of the following:

16 “(aa) Full-benefit dual eligi-
17 ble individuals (as defined in sec-
18 tion 1935(e)(6)).

19 “(bb) Such individuals not
20 described in item (aa).

21 “(IV) EVALUATION OF MENTAL
22 HEALTH AND SUBSTANCE USE DIS-
23 ORDERS.—The Secretary shall evalu-
24 ate the impact of including additional
25 diagnosis codes related to mental

1 health and substance use disorders in
2 the risk adjustment model.

3 “(V) EVALUATION OF CHRONIC
4 KIDNEY DISEASE.—The Secretary
5 shall evaluate the impact of including
6 diagnosis codes related to the severity
7 of chronic kidney disease in the risk
8 adjustment model.

9 “(VI) EVALUATION OF PAYMENT
10 RATES FOR END-STAGE RENAL DIS-
11 EASE.—The Secretary shall evaluate
12 whether other factors (in addition to
13 those described in subparagraph (H))
14 should be taken into consideration
15 when computing payment rates under
16 such subparagraph.

17 “(ii) PHASED-IN IMPLEMENTATION.—
18 The Secretary shall phase-in any changes
19 to risk adjustment payment amounts under
20 subparagraph (C)(i) under this subpara-
21 graph over a 3-year period, beginning with
22 2019, with such changes being fully imple-
23 mented for 2022 and subsequent years.

24 “(iii) OPPORTUNITY FOR REVIEW AND
25 PUBLIC COMMENT.—The Secretary shall

1 provide an opportunity for review of the
2 proposed changes to such risk adjustment
3 payment amounts under this subparagraph
4 and a public comment period of not less
5 than 60 days before implementing such
6 changes.”.

7 (b) STUDIES AND REPORTS.—

8 (1) REPORTS ON THE RISK ADJUSTMENT SYS-
9 TEM.—

10 (A) MEDPAC EVALUATION AND RE-
11 PORT.—

12 (i) EVALUATION.—The Medicare Pay-
13 ment Advisory Commission shall conduct
14 an evaluation of the impact of the provi-
15 sions of, and amendments made by, this
16 section on risk scores for enrollees in Medi-
17 care Advantage plans under part C of title
18 XVIII of the Social Security Act and pay-
19 ments to Medicare Advantage plans under
20 such part, including the impact of such
21 provisions and amendments on the overall
22 accuracy of risk scores under the Medicare
23 Advantage program.

24 (ii) REPORT.—Not later than July 1,
25 2020, the Medicare Payment Advisory

1 Commission shall submit to Congress a re-
2 port on the evaluation under clause (i), to-
3 gether with recommendations for such leg-
4 islation and administrative action as the
5 Commission determines appropriate.

6 (B) REPORTS BY SECRETARY OF HEALTH
7 AND HUMAN SERVICES.—Not later than Decem-
8 ber 31, 2018, and every 3 years thereafter, the
9 Secretary of Health and Human Services shall
10 submit to Congress a report on the risk adjust-
11 ment model and the ESRD risk adjustment
12 model under the Medicare Advantage program
13 under part C of title XVIII of the Social Secu-
14 rity Act, including any revisions to either such
15 model since the previous report. Such report
16 shall include information on how such revisions
17 impact the predictive ratios under either such
18 model for groups of enrollees in Medicare Ad-
19 vantage plans, including very high and very low
20 cost enrollees, and groups defined by the num-
21 ber of chronic conditions of enrollees.

22 (2) STUDY AND REPORT ON FUNCTIONAL STA-
23 TUS.—

24 (A) STUDY.—The Comptroller General of
25 the United States (in this paragraph referred to

1 as the “Comptroller General”) shall conduct a
2 study on how to most accurately measure the
3 functional status of enrollees in Medicare Ad-
4 vantage plans and whether the use of such
5 functional status would improve the accuracy of
6 risk adjustment payments under the Medicare
7 Advantage program under part C of title XVIII
8 of the Social Security Act. Such study shall in-
9 clude an analysis of the challenges in collecting
10 and reporting functional status information for
11 Medicare Advantage plans under such part,
12 providers of services and suppliers under the
13 Medicare program, and the Centers for Medi-
14 care & Medicaid Services.

15 (B) REPORT.—Not later than June 30,
16 2018, the Comptroller General shall submit to
17 Congress a report containing the results of the
18 study under subparagraph (A), together with
19 recommendations for such legislation and ad-
20 ministrative action as the Comptroller General
21 determines appropriate.

1 **SEC. 402. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO**
2 **BE PART OF AN ACCOUNTABLE CARE ORGA-**
3 **NIZATION.**

4 Section 1899(c) of the Social Security Act (42 U.S.C.
5 1395jjj(c)) is amended—

6 (1) by striking “ACOs.—The Secretary” and
7 inserting “ACOs.—

8 “(1) IN GENERAL.—Subject to paragraph (2),
9 the Secretary”; and

10 (2) by adding at the end the following new
11 paragraph:

12 “(2) PROVIDING FLEXIBILITY.—For each
13 agreement period (effective for agreements entered
14 into or renewed on or after January 1, 2019), the
15 following shall apply:

16 “(A) CHOICE OF PROSPECTIVE ASSIGN-
17 MENT.—In the case where an ACO established
18 under the program is in a Track that provides
19 for the retrospective assignment of Medicare
20 fee-for-service beneficiaries to the ACO, the
21 Secretary shall permit the ACO to choose to
22 have Medicare fee-for-service beneficiaries as-
23 signed prospectively, rather than retrospec-
24 tively, to the ACO for an agreement period.

1 “(B) ASSIGNMENT BASED ON VOLUNTARY
2 IDENTIFICATION BY MEDICARE FEE-FOR-SERV-
3 ICE BENEFICIARIES.—

4 “(i) IN GENERAL.—The Secretary
5 shall permit a Medicare fee-for-service ben-
6 efiary to voluntarily identify an ACO pro-
7 fessional as the primary care provider of
8 the beneficiary for purposes of assigning
9 such beneficiary to an ACO, as determined
10 by the Secretary.

11 “(ii) NOTIFICATION PROCESS.—The
12 Secretary shall establish a process under
13 which a Medicare fee-for-service bene-
14 ficiary is—

15 “(I) notified of their ability to
16 make an identification described in
17 clause (i); and

18 “(II) informed of the process by
19 which they may make and change
20 such identification.

21 “(iii) SUPERSEDING CLAIMS-BASED
22 ASSIGNMENT.—A voluntary identification
23 by a Medicare fee-for-service beneficiary
24 under this subparagraph shall supersede

1 any claims-based assignment otherwise de-
2 termined by the Secretary.”.

3 **TITLE V—EMPOWERING INDI-**
4 **VIDUALS AND CAREGIVERS IN**
5 **CARE DELIVERY**

6 **SEC. 501. ELIMINATING BARRIERS TO CARE COORDINA-**
7 **TION UNDER ACCOUNTABLE CARE ORGANI-**
8 **ZATIONS.**

9 (a) IN GENERAL.—Section 1899 of the Social Secu-
10 rity Act (42 U.S.C. 1395jjj), as amended by section
11 304(a), is amended—

12 (1) in subsection (b)(2), by adding at the end
13 the following new subparagraph:

14 “(I) An ACO that seeks to operate an
15 ACO Beneficiary Incentive Program pursuant
16 to subsection (m) shall apply to the Secretary
17 at such time, in such manner, and with such in-
18 formation as the Secretary may require.”;

19 (2) by adding at the end the following new sub-
20 section:

21 “(m) AUTHORITY TO PROVIDE INCENTIVE PAY-
22 MENTS TO BENEFICIARIES WITH RESPECT TO QUALI-
23 FYING PRIMARY CARE SERVICES.—

24 “(1) PROGRAM.—

1 “(A) IN GENERAL.—In order to encourage
2 Medicare fee-for-service beneficiaries to obtain
3 medically necessary primary care services, an
4 ACO participating under this section under a
5 payment model described in clause (i) or (ii) of
6 paragraph (2)(B) may apply to establish an
7 ACO Beneficiary Incentive Program to provide
8 incentive payments to such beneficiaries who
9 are furnished qualifying services in accordance
10 with this subsection. The Secretary shall permit
11 such an ACO to establish such a program at
12 the Secretary’s discretion and subject to such
13 requirements, including program integrity re-
14 quirements, as the Secretary determines nec-
15 essary.

16 “(B) IMPLEMENTATION.—The Secretary
17 shall implement this subsection on a date deter-
18 mined appropriate by the Secretary. Such date
19 shall be no earlier than January 1, 2018, and
20 no later than January 1, 2019.

21 “(2) CONDUCT OF PROGRAM.—

22 “(A) DURATION.—Subject to subpara-
23 graph (H), an ACO Beneficiary Incentive Pro-
24 gram established under this subsection shall be

1 conducted for such period (of not less than 1
2 year) as the Secretary may approve.

3 “(B) SCOPE.—An ACO Beneficiary Incentive Program established under this subsection
4 shall provide incentive payments to all of the
5 following Medicare fee-for-service beneficiaries
6 who are furnished qualifying services by the
7 ACO:
8

9 “(i) With respect to the Track 2 and
10 Track 3 payment models described in section 425.600(a) of title 42, Code of Federal Regulations (or in any successor regulation), Medicare fee-for-service beneficiaries who are preliminarily prospectively
11 or prospectively assigned (or otherwise assigned, as determined by the Secretary) to
12 the ACO.
13
14
15
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17

18 “(ii) With respect to any future payment models involving two-sided risk, Medicare fee-for-service beneficiaries who
19 are assigned to the ACO, as determined by
20 the Secretary.
21

22 “(C) QUALIFYING SERVICE.—For purposes
23 of this subsection, a qualifying service is a primary care service, as defined in section 425.20
24
25

1 of title 42, Code of Federal Regulations (or in
2 any successor regulation), with respect to which
3 coinsurance applies under part B, furnished
4 through an ACO by—

5 “(i) an ACO professional described in
6 subsection (h)(1)(A) who has a primary
7 specialty designation of internal medicine,
8 general practice, family practice, geriatric
9 medicine, or pediatric medicine;

10 “(ii) an ACO professional described in
11 subsection (h)(1)(B); or

12 “(iii) a Federally qualified health cen-
13 ter or rural health clinic (as such terms
14 are defined in section 1861(aa)).

15 “(D) INCENTIVE PAYMENTS.—An incentive
16 payment made by an ACO pursuant to an ACO
17 Beneficiary Incentive Program established
18 under this subsection shall be—

19 “(i) in an amount up to \$20, with
20 such maximum amount updated annually
21 by the percentage increase in the consumer
22 price index for all urban consumers
23 (United States city average) for the 12-
24 month period ending with June of the pre-
25 vious year;

1 “(ii) in the same amount for each
2 Medicare fee-for-service beneficiary de-
3 scribed in clauses (i) or (ii) of subpara-
4 graph (B) without regard to enrollment of
5 such a beneficiary in a medicare supple-
6 mental policy (described in section
7 1882(g)(1)), in a State Medicaid plan
8 under title XIX or a waiver of such a plan,
9 or in any other health insurance policy or
10 health benefit plan;

11 “(iii) made for each qualifying service
12 furnished to such a beneficiary described
13 in clause (i) or (ii) of subparagraph (B)
14 during a period specified by the Secretary;
15 and

16 “(iv) made no later than 30 days after
17 a qualifying service is furnished to such a
18 beneficiary described in clause (i) or (ii) of
19 subparagraph (B).

20 “(E) NO SEPARATE PAYMENTS FROM THE
21 SECRETARY.—The Secretary shall not make
22 any separate payment to an ACO for the costs,
23 including incentive payments, of carrying out
24 an ACO Beneficiary Incentive Program estab-
25 lished under this subsection. Nothing in this

1 subparagraph shall be construed as prohibiting
2 an ACO from using shared savings received
3 under this section to carry out an ACO Bene-
4 ficiary Incentive Program.

5 “(F) NO APPLICATION TO SHARED SAV-
6 INGS CALCULATION.—Incentive payments made
7 by an ACO under this subsection shall be dis-
8 regarded for purposes of calculating bench-
9 marks, estimated average per capita Medicare
10 expenditures, and shared savings under this
11 section.

12 “(G) REPORTING REQUIREMENTS.—An
13 ACO conducting an ACO Beneficiary Incentive
14 Program under this subsection shall, at such
15 times and in such format as the Secretary may
16 require, report to the Secretary such informa-
17 tion and retain such documentation as the Sec-
18 retary may require, including the amount and
19 frequency of incentive payments made and the
20 number of Medicare fee-for-service beneficiaries
21 receiving such payments.

22 “(H) TERMINATION.—The Secretary may
23 terminate an ACO Beneficiary Incentive Pro-
24 gram established under this subsection at any

1 (3) by adding at the end the following new sub-
2 paragraph:

3 “(K) an incentive payment made to a
4 Medicare fee-for-service beneficiary by an ACO
5 under an ACO Beneficiary Incentive Program
6 established under subsection (m) of section
7 1899, if the payment is made in accordance
8 with the requirements of such subsection and
9 meets such other conditions as the Secretary
10 may establish.”.

11 **SEC. 502. GAO STUDY AND REPORT ON LONGITUDINAL**
12 **COMPREHENSIVE CARE PLANNING SERVICES**
13 **UNDER MEDICARE PART B.**

14 (a) STUDY.—The Comptroller General shall conduct
15 a study on the establishment under part B of the Medicare
16 program under title XVIII of the Social Security Act of
17 a payment code for a one-time visit for longitudinal com-
18 prehensive care planning services. Such study shall include
19 an analysis of the following:

20 (1) The frequency with which services similar to
21 longitudinal comprehensive care planning services
22 are furnished to Medicare beneficiaries, which pro-
23 viders of services and suppliers are furnishing those
24 services, whether Medicare reimbursement is being

1 received for those services, and, if so, through which
2 codes those services are being reimbursed.

3 (2) Whether, and the extent to which, longitu-
4 dinal comprehensive care planning services would
5 overlap, and could therefore result in duplicative
6 payment, with services covered under the hospice
7 benefit as well as the chronic care management code,
8 evaluation and management codes, or other codes
9 that already exist under part B of the Medicare pro-
10 gram.

11 (3) Any barriers to hospitals, skilled nursing fa-
12 cilities, hospice programs, home health agencies, and
13 other applicable providers working with a Medicare
14 beneficiary to engage in the care planning process
15 and complete the necessary documentation to sup-
16 port the treatment and care plan of the beneficiary
17 and provide such documentation to other providers
18 and the beneficiary or his representative.

19 (4) Any barriers to providers, other than the
20 provider furnishing longitudinal comprehensive care
21 planning services, accessing the care plan and asso-
22 ciated documentation for use related to the care of
23 the Medicare beneficiary.

24 (5) The feasibility and appropriateness of the
25 Secretary requiring adherence to the care plan as a

1 condition of Medicare participation and a condition
2 of receiving payment for longitudinal comprehensive
3 care planning services, including how differences in
4 State laws may or may not affect the ability of the
5 Secretary to enforce such requirements.

6 (6) The need for the development of quality
7 metrics with respect to longitudinal comprehensive
8 care planning services, such as measures related
9 to—

10 (A) the process of eliciting input from the
11 Medicare beneficiary or from a legally author-
12 ized representative and documenting in the
13 medical record the patient-directed care plan;

14 (B) the effectiveness and patient-
15 centeredness of the care plan in organizing de-
16 livery of services consistent with the plan;

17 (C) the availability of the care plan and as-
18 sociated documentation to other providers that
19 care for the beneficiary; and

20 (D) the extent to which the beneficiary re-
21 ceived services and support that is free from
22 discrimination based on advanced age, disability
23 status, or advanced illness.

24 (7) How such quality metrics would provide in-
25 formation on—

1 (A) the goals, values, and preferences of
2 the beneficiary;

3 (B) the documentation of the care plan;

4 (C) services furnished to the beneficiary;

5 and

6 (D) outcomes of treatment.

7 (8) What type of training and education is
8 needed for applicable providers, individuals, and
9 caregivers in order to facilitate longitudinal com-
10 prehensive care planning services.

11 (9) Which providers of services and suppliers
12 should be included in the interdisciplinary team of
13 an applicable provider.

14 (10) Which population of Medicare beneficiaries
15 would be the most appropriate to receive longitu-
16 dinal comprehensive care planning services, which
17 may include the following:

18 (A) An individual diagnosed with Alz-
19 heimer's disease or other dementia.

20 (B) An individual diagnosed with meta-
21 static or locally advanced cancer.

22 (C) An individual diagnosed with late-stage
23 neuromuscular disease.

24 (D) An individual diagnosed with late-
25 stage diabetes.

1 (E) An individual diagnosed with late-stage
2 kidney, liver, heart, gastrointestinal, cerebro-
3 vascular, or lung disease.

4 (F) An individual who needs assistance
5 with two or more activities of daily living (de-
6 fined as bathing, dressing, eating, getting out of
7 bed or a chair, mobility, and toileting) not asso-
8 ciated with acute or post-operative conditions
9 that are caused by one or more serious or life-
10 threatening illnesses or frailties.

11 (11) Whether longitudinal comprehensive care
12 planning services should be furnished more fre-
13 quently than once upon initial diagnosis, such as
14 once yearly or with each significant progression of
15 the illness.

16 (b) REPORT.—Not later than 9 months after the date
17 of the enactment of this Act, the Comptroller General shall
18 submit to Congress a report containing the results of the
19 study conducted under subsection (a), together with rec-
20 ommendations for such legislation and administrative ac-
21 tion as the Comptroller General determines appropriate.

22 (c) DEFINITIONS.—In this section:

23 (1) APPLICABLE PROVIDER.—The term “appli-
24 cable provider” means a hospice program (as defined
25 in subsection (dd)(2) of section 1861 of the Social

1 Security Act (42 U.S.C. 1395ww)) or other provider
2 of services (as defined in subsection (u) of such sec-
3 tion) or supplier (as defined in subsection (d) of
4 such section) that—

5 (A) furnishes longitudinal comprehensive
6 care planning services through an interdiscipli-
7 nary team; and

8 (B) meets such other requirements as the
9 Secretary may determine to be appropriate.

10 (2) **COMPTROLLER GENERAL.**—The term
11 “Comptroller General” means the Comptroller Gen-
12 eral of the United States.

13 (3) **INTERDISCIPLINARY TEAM.**—The term
14 “interdisciplinary team” means a group that—

15 (A) includes the personnel described in
16 subsection (dd)(2)(B)(i) of such section 1861;

17 (B) may include a chaplain, minister, or
18 other clergy; and

19 (C) may include other direct care per-
20 sonnel.

21 (4) **LONGITUDINAL COMPREHENSIVE CARE**
22 **PLANNING SERVICES.**—The term “longitudinal com-
23 prehensive care planning services” means a vol-
24 untary shared decision-making process that is fur-
25 nished by an applicable provider through an inter-

1 disciplinary team and includes a conversation with
2 Medicare beneficiaries who have received a diagnosis
3 of a serious or life-threatening illness. The purpose
4 of such services is to discuss a longitudinal care plan
5 that addresses the progression of the disease, treat-
6 ment options, the goals, values, and preferences of
7 the beneficiary, and the availability of other re-
8 sources and social supports that may reduce the
9 beneficiary’s health risks and promote self-manage-
10 ment and shared decision making.

11 (5) SECRETARY.—The term “Secretary” means
12 the Secretary of Health and Human Services.

13 **TITLE VI—OTHER POLICIES TO**
14 **IMPROVE CARE FOR THE**
15 **CHRONICALLY ILL**

16 **SEC. 601. GAO STUDY AND REPORT ON IMPROVING MEDI-**
17 **CATION SYNCHRONIZATION.**

18 (a) STUDY.—The Comptroller General of the United
19 States (in this section referred to as the “Comptroller
20 General”) shall conduct a study on the extent to which
21 Medicare prescription drug plans (MA–PD plans and
22 standalone prescription drug plans) under part D of title
23 XVIII of the Social Security Act and private payors use
24 programs that synchronize pharmacy dispensing so that
25 individuals may receive multiple prescriptions on the same

1 day to facilitate comprehensive counseling and promote
2 medication adherence. The study shall include an analysis
3 of the following:

4 (1) The prevalence of such programs.

5 (2) The common characteristics of such pro-
6 grams, including how pharmacies structure coun-
7 seling sessions under such programs and the types
8 of payment and other arrangements that Medicare
9 prescription drug plans and private payors employ
10 under such programs to support the efforts of phar-
11 macies.

12 (3) The extent to which common characteristics
13 of such programs are different for Medicare pre-
14 scription drug plans and private payors.

15 (4) The impact of such programs on patient
16 medication adherence and, to the extent practicable,
17 overall patient health outcomes and health outcomes
18 by patient subpopulations, such as disease state and
19 socioeconomic status.

20 (5) To the extent practicable, overall patient
21 satisfaction with such programs and satisfaction
22 with such programs within patient subpopulations,
23 such as disease state and socioeconomic status.

24 (6) The extent to which laws and regulations of
25 the Medicare program support such programs.

1 (7) Barriers to the use of medication synchroni-
2 zation programs by Medicare prescription drug
3 plans.

4 (b) REPORT.—Not later than 1 year after the date
5 of enactment of this Act, the Comptroller General shall
6 submit to Congress a report containing the results of the
7 study under subsection (a), together with recommenda-
8 tions for such legislation and administrative action as the
9 Comptroller General determines appropriate.

10 **SEC. 602. GAO STUDY AND REPORT ON IMPACT OF OBESITY**
11 **DRUGS ON PATIENT HEALTH AND SPENDING.**

12 (a) STUDY.—The Comptroller General of the United
13 States (in this section referred to as the “Comptroller
14 General”) shall conduct a study on the use of prescription
15 drugs to manage the weight of obese patients and the im-
16 pact of coverage of such drugs on patient health and on
17 health care spending. Such study shall examine the use
18 and impact of these obesity drugs in the non-Medicare
19 population and for Medicare beneficiaries who have such
20 drugs covered through an MA–PD plan (as defined in sec-
21 tion 1860D–1(a)(3)(C) of the Social Security Act (42
22 U.S.C. 1395w–101(a)(3)(C))) as a supplemental health
23 care benefit. The study shall include an analysis of the
24 following:

1 (1) The prevalence of obesity in the Medicare
2 and non-Medicare population.

3 (2) The utilization of obesity drugs.

4 (3) The distribution of Body Mass Index by in-
5 dividuals taking obesity drugs, to the extent prac-
6 ticable.

7 (4) The extent to which use of obesity drugs is
8 in conjunction with the receipt of other items or
9 services, such as behavioral counseling.

10 (5) Physician considerations and attitudes re-
11 lated to prescribing obesity drugs.

12 (6) The extent to which coverage policies cease
13 or limit coverage for individuals who fail to receive
14 clinical benefit.

15 (7) The extent to which individuals who take
16 obesity drugs adhere to the prescribed regimen.

17 (8) The extent to which individuals who take
18 obesity drugs maintain weight loss over time.

19 (9) The subsequent impact such drugs have on
20 medical services that are directly related to obesity,
21 including with respect to subpopulations determined
22 based on the extent of obesity.

23 (10) The medical and other items and services
24 received by obese individuals who do not take obesity
25 drugs.

1 (11) The spending associated with the care of
2 individuals who take obesity drugs, compared to the
3 spending associated with the care of individuals who
4 do not take such drugs.

5 (b) REPORT.—Not later than 1 year after the date
6 of enactment of this Act, the Comptroller General shall
7 submit to Congress a report containing the results of the
8 study under subsection (a), together with recommenda-
9 tions for such legislation and administrative action as the
10 Comptroller General determines appropriate.

11 **TITLE VII—OFFSETS**

12 **SEC. 701. OFFSETS TO BE SUPPLIED.**