The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017

Section-By-Section Summary

TITLE I – RECEIVING HIGH QUALITY CARE IN THE HOME

Section 101. Extending the Independence at Home Model of Care

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) created the Independence at Home (IAH) demonstration under the Medicare program to test a payment incentive and service delivery model that uses physician and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable Medicare beneficiaries with multiple chronic illnesses. Medical practice staff are required to make in-home visits and to be available 24 hours per day, seven days per week to implement care plans tailored to the individual beneficiary's chronic conditions. Under the IAH demonstration, qualifying medical practices continue to receive traditional Medicare fee-for-service payments for services furnished but are eligible for incentive payments, subject to meeting performance standards on quality measures, if actual annual expenditures for applicable beneficiaries are less than the estimated spending target for the year. In the first performance year, 17 participating practices served more than 8,400 Medicare beneficiaries. In the second year, 15 practices served over 10,000 beneficiaries. The demonstration began on June 1, 2012, and will end on September 30, 2017.

This section would extend and expand the promising IAH demonstration to provide a broader base of experience to inform future legislative efforts. Specifically, it would extend the length of the demonstration by two years, through September 30, 2019; increase the cap on the total number of participating beneficiaries from 10,000 to 15,000; and give practices three years to generate savings against their spending targets. Currently, practices are to be terminated if they do not receive an incentive payment for spending at least 5 percent less than their targets in two consecutive years.

Section 102. Expanding Access to Home Dialysis Therapy

Medicare requires that a beneficiary receiving dialysis treatment in his or her home receive a monthly clinical assessment with his or her clinician, often a nephrologist, to review lab work, check for complications, answer questions, and discuss the effectiveness of treatment. Beneficiaries can utilize telehealth to receive this visit only if it occurs in a) an authorized originating site (including a physician office and hospital-based dialysis facility) and b) the site is located in a rural Health Professional Shortage Area (HPSA) or county outside a Metropolitan Statistical Area (MSA).

This section would expand the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth, beginning in 2019. Specifically, it expands the number of originating sites from which the beneficiary can have a telehealth assessment with his or her clinician to include freestanding dialysis facilities and the patient's home; and enables

these telehealth visits to be conducted from the expanded list of sites without geographic restriction. A beneficiary would be required to have a face-to-face clinical assessment – without the use of telehealth – at least once every three months. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home.

TITLE II – ADVANCING TEAM BASED CARE

Section 201. Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established a new Medicare Advantage (MA) coordinated care plan to provide services for individuals with special needs. Special needs plans (SNPs) are permitted to target enrollment to one or more types of special needs individuals, including those who are (1) institutionalized, (2) dually eligible for both Medicare and Medicaid, or (3) living with severe or disabling chronic conditions. Among other changes, the Affordable Care Act extended SNP authority through December 31, 2013, and temporarily extended authority through the end of 2012 for dual eligible SNPs without contracts with state Medicaid programs to continue to operate, but in their current service areas. After 2012, dual eligible SNPs, new and renewing, were required to have contracts with state Medicaid agencies. Several subsequent laws have extended SNP authority without interruption; most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

In this section, the Medicare-Medicaid Coordination Office would be directed to serve as a dedicated point of contact for states to assist with Medicare and Medicaid integration efforts, and the Secretary would be required to work through this office to establish a unified grievances and appeals process for individuals enrolled in a D-SNP. This section would permanently authorize the I-SNP, D-SNP and C-SNP, if certain requirements are met. By 2021, a D-SNP contract would be required to have a unified grievances and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid long-term services and supports and/or behavioral health services by meeting one of three requirements. Beginning in 2020, a C-SNP would be required to meet additional requirements to improve care management for the beneficiaries with severe or disabling chronic conditions enrolled in the plan. By January 1, 2022, and every five years thereafter, the Secretary would be required to update the list of chronic conditions eligible for participation in a C-SNP. The Secretary may consider implementing the quality star rating system at the plan level for SNPs and all MA plans.

TITLE III – EXPANDING INNOVATION AND TECHNOLOGY

Section 301. Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Under Medicare Advantage (MA) private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll. Unlike original Medicare, where providers are paid for each item or service provided to a beneficiary, an MA plan receives the same capitated monthly payment regardless of how many or few services a beneficiary actually uses. The plan is at-risk if aggregate costs for its enrollees exceed program payments and

beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing. Currently, an MA plan must offer the same benefit package to all of its enrollees. The Centers for Medicare and Medicaid Innovations (CMMI) is currently testing a model to allow greater flexibility for an MA plan to meet the needs of chronically ill enrollees.

This section would expand the testing of the CMMI Value-Based Insurance Design (VBID) Model to allow an MA plan in any state to participate in the model by 2020 (during the testing phase) to determine whether savings are achieved without negatively impacting quality.

Section 302. Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

All Medicare Advantage (MA) plans must offer required Medicare benefits (except hospice) and may offer additional or supplemental benefits. Mandatory supplemental benefits are covered by the MA plan for every person enrolled in the plan and are paid for either through plan rebates, a beneficiary premium, or cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollee may choose to pay an additional amount to receive coverage of the optional benefit; optional benefits cannot be financed through plan rebates.

An MA plan must adhere to specific rules regarding the supplemental benefits that it can offer. First, the MA plan cannot design a benefit plan that is likely to substantially discourage enrollment by certain MA eligible individuals. Further, supplemental benefits (a) may not be Medicare Part A or Part B required services, (b) must be primarily health related with the primary purpose to prevent, cure, or diminish an illness or injury, and (c) the plan must incur a cost when providing the benefit. Items that are primarily for comfort or are considered social services would not qualify as supplemental benefits. Examples of supplemental benefits include the following:

(a) Additional inpatient hospital days in an acute care or psychiatric facility,
(b) Acupuncture or alternative therapies,
(c) Counseling services,
(d) Fitness benefit,
(e) Enhanced disease management, and
(f) Remote Access Technologies (including Web/Phone based technologies).

This section would allow an MA plan to offer a wider array of supplemental benefits to chronically ill enrollees beginning in 2020. These supplemental benefits would be required to have a reasonable expectation of improving or maintaining the health or overall function of the chronically-ill enrollee and would not be limited to primarily health related services. The section would allow an MA plan the flexibility to provide targeted supplemental benefits to specific chronically ill enrollees.

Section 303. Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Telehealth is the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, and other health care delivery functions. While Medicare beneficiaries may receive telehealth services in a variety of settings, under

current law (SSA Section 1834(m)), the Medicare program recognizes and pays for only certain Part B telehealth services. These services must be either (1) remote patient and physician/professional face-to-face services delivered via a telecommunications system (e.g., live video conferencing), or (2) non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services in the case of any Federal telemedicine demonstration program in Alaska or Hawaii. Typically, Medicare coverage for remote face-to-face services includes payments (1) to physicians or other professionals (at the distant site) for the telehealth consultation, and (2) to the facility where the patient is located (the originating site).

An MA plan may provide basic telehealth benefits as part of the standard benefit; for example, telemonitoring and web-based and phone technologies can be used to provide telehealth services. Medicare Advantage Prescription Drug (MAPD) may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management (MTM). However, while there is nothing to preclude Medicare Advantage (MA) from providing telemedicine or other technologies that they believe promote efficiencies beyond what is covered in the traditional Medicare program, those services and technologies are not separately paid for by Medicare and plans must use their rebate dollars to pay for those services as a supplemental benefit.

This section would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. The Secretary would be required to solicit comments on: what types of telehealth services, including but not limited to those provided through supplemental health care benefits, offered as supplemental benefits should be considered to be additional telehealth benefits; the requirements for furnishing those benefits. If an MA plan provides access to a service via telehealth, the MA plan must also provide access to that service through an in-person visit, and the beneficiary would have the ability to decide whether or not to receive the service via telehealth.

Section 304. Providing Accountable Care Organizations the Ability to Expand Use of Telehealth

While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program restricts telehealth payments by the type of services provided, the geographic location where the services are delivered, the type of institution delivering the services, and the type of health provider. While there is nothing to preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare. Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs. Telehealth may have the potential to replace some face-to-face office visits, reduce emergency room visits, and prevent hospitalizations. Telehealth may also keep beneficiaries in closer, more consistent contact with providers.

This section would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective assignment and remains at two-sided risk), MSSP Track III, and two-sided risk ACO models with prospective assignment that are tested or expanded through the Center for Medicare & Medicaid Innovation (CMMI) as determined appropriate by the Secretary. This provision would (1) eliminate the geographic component of the originating site requirement, (2) allow beneficiaries assigned to the approved MSSP and ACO

programs to receive currently allowable telehealth services in the home, and (3) ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare's physician fee schedule, with limited exceptions. To be eligible for Medicare payment, the beneficiary must be located at an originating site that is either (1) one of the approved sites listed in Section 1834(m)(4)(C)(ii) of the Social Security Act, or (2) the beneficiary's place of residence. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home.

Section 305. Expanding Use of Telehealth for Individuals with Stroke

Currently, Medicare pays for physician services involved in stroke treatment under the Physician Fee Schedule, with the hospital being paid under the Hospital Outpatient Prospective Payment System and Inpatient Prospective Payment System. While many of these physician services are furnished on-site when the beneficiary presents symptoms of stroke at the hospital emergency department, Medicare will pay a physician, at a distant site, for consulting on a patient experiencing acute stroke symptoms via telehealth if the originating site hospital, where the beneficiary presents, is in a rural HPSA or a county outside an MSA.

This section would expand the ability of patients presenting with stroke symptoms to receive a timely consultation to determine the best course of treatment through telehealth, beginning in 2021. Specifically, it would eliminate the geographic restriction as to permit payment to a physician furnishing the telehealth consultation service in all areas of the country. The hospitals that are newly eligible to serve as a site from which a paid telehealth consultation is initiated would not receive a separate originating site payment.

TITLE IV – IDENTIFYING THE CHRONICALLY ILL POPULATION

Section 401. Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization

Medicare fee-for-service beneficiaries are assigned to ACOs based on their utilization of primary care services provided by a physician who is an ACO provider and/or supplier. Beneficiaries currently do not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider), but are notified if their primary care provider is an ACO participant. Beneficiaries who receive at least one primary care service from a primary care physician within the ACO may be assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO, but who receive at least one primary care service from any physician within the ACO, are assigned to that ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians.

The manner in which Medicare fee-for-service beneficiaries are assigned to an ACO affects how the ACO can tailor care for its beneficiaries and how the ACO is evaluated. Under current Centers for Medicare & Medicaid (CMS) rules, Medicare determines the method of beneficiary attribution, rather than giving ACOs the option to choose the assignment methodology that best fits their model of care. Medicare fee-for-service beneficiaries can be assigned to an ACO either retrospectively or prospectively depending on the ACO's track. Prospective assignment allows ACOs to identify

beneficiaries for whom they will be held accountable and proactively take steps to connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care. Retrospective assignment ensures that ACOs are held accountable for the spending only of those beneficiaries who receive most of their primary care services from ACO providers, but they may not know who those beneficiaries are until the end of the year.

This section would amend Section 1899(c) of the Social Security Act to give ACOs in the MSSP the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. Additionally, this provision would give a beneficiary the option to voluntarily align to the MSSP ACO in which the beneficiary's main primary care provider is participating. The Secretary of HHS would establish a process by which beneficiaries are notified of their ability to make such an election as well as the process by which they may change such election. The beneficiary would retain his or her freedom of choice to see any provider.

TITLE V – EMPOWERING INDIVIDUALS AND CAREGIVERS IN CARE DELIVERY

Section 501. Eliminating Barriers to Care Coordination under Accountable Care Organizations

ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, federally qualified health centers, rural health clinics, and others. In the Medicare Shared Savings Program (MSSP) specifically, ACOs are designed to provide incentives to providers to manage care across the continuum by reducing health care costs while meeting quality performance standards. The ACO mission is to ensure that patients, especially the chronically ill, receive the right care at the right time in the right care setting, while avoiding unnecessary duplication of services and preventing medical errors. Delaying or forgoing preventive care – especially care related to chronic disease management – may lead to increased costs and poor health outcomes. ACOs are accountable for the health outcomes and overall costs of their attributed beneficiaries. As a result, ACO aligned beneficiaries could be encouraged to seek out preventive care or chronic disease management if the cost to access those services is manageable.

This section would establish the ACO Beneficiary Incentive Program. This new program would create a process that allows certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services. Eligible ACOs would be allowed to offer a flat payment, of up to $20 per qualifying service, directly to the beneficiary. This program is voluntary. These ACOs would not be provided additional Medicare reimbursement to cover the primary care incentive payment costs. Permitting this option under a two-sided risk model would give these ACOs an additional tool to achieve better health outcomes for beneficiaries – as well as produce cost savings for both the ACO and the Medicare program. President Obama's Fiscal Year (FY) 2017 budget contained a similar policy proposal. Additionally, this section requires HHS to conduct an evaluation of the Beneficiary Incentive Program. The report must include an analysis of the impact of this program's implementation on expenditures and beneficiary health outcomes. A report to Congress is due no later October 1, 2023.

Section 502. GAO Study on Serious or Life Threatening Illness

Diagnoses of serious or life-threatening illnesses—such as Alzheimer's disease and other dementias, cancer, and neuromuscular disease—are devastating to Medicare beneficiaries and their families. Some of these illnesses do not have a predictable disease progression, do not have an arsenal of treatment options that can be immediately deployed, and symptoms may not manifest for years. These circumstances make it imperative that a discussion between the patient and his or her provider occurs upon diagnosis.

This section would direct Government Accountability Office (GAO) to submit a report to Congress within 18 months of the date of enactment to inform the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness. Specifically, GAO would identify the extent to which such a comprehensive longitudinal care planning service is provided to beneficiaries, whether there would be any duplication in payment for such service with billing codes for which Medicare current pays, and barriers to hospitals, skilled nursing facilities, hospice programs, home health agencies, and other providers working with a Medicare beneficiary to engage in the care planning process. It would also identify any barriers to providers accessing the care plan and options for promoting adherence to it. In addition, GAO would assess the need to develop quality metrics related to care planning, the characteristics of Medicare beneficiaries who would be most appropriate to receive longitudinal planning services, and the providers best suited to furnish the service as a part of a multi-disciplinary team.

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

Section 601. Providing Prescription Drug Plans with Parts A and Part B Claims Data to Promote the Appropriate Use of Medications and Improve Health Outcomes

Under current law, standalone prescription drug plans (PDPs) provide Medicare's prescription drug benefit to fee-for-service (FFS) beneficiaries. Certain Medicare beneficiaries who meet criteria described in statute are eligible to enroll in medication therapy management (MTM) programs offered by PDPs. MTM's purpose is to coordinate prescription drugs for high-cost beneficiaries. However, PDPs do not have access FFS utilization data that may aid the PDP in coordination efforts. This differs from MA-PDs which are responsible for providing both Medicare's prescription drug benefit but also Medicare Part A and Part B's medical benefits and has access to all relevant data.

This section would require the Secretary to establish a process, beginning in plan year 2020, by which a Part D plan sponsor may submit a request to HHS for claims data under Parts A and B. These data, which would include claims as recent as possible, would be for the purposes of: optimizing therapeutic outcomes through improved medication use; improving care coordination as to prevent adverse health outcomes; and other purposes determined by the Secretary. Plan sponsors would be prohibited from using these data to: inform Part D coverage determinations; conduct retroactive review of coverage indications; facilitate enrollment changes to a different PDP or an MA-PD offered by the same parent organization; market benefits; and for other purposes determined by the Secretary to protect the identity of Medicare beneficiaries and to protect the security of personal health information.

Section 602. GAO Study and Report on Improving Medication Synchronization

In April 2012, the Centers for Medicare & Medicaid Services (CMS) finalized a rule requiring daily cost-sharing requirements for Medicare Part D prescription drugs. Beginning in 2014, CMS requires that Part D sponsors establish and apply a daily cost sharing rate whenever a prescription is dispensed by a network pharmacy for less than 30 days' supply, unless the drug is exempted by regulation. This rule applies regardless of the setting in which the applicable drugs are dispensed. The daily cost-sharing rule does not address how pharmacy dispensing fees are to be negotiated, calculated, or paid and the rule does not require the proration of pharmacy dispensing fees. Individuals with chronic diseases often take multiple prescriptions that are prescribed by different clinicians. Because most prescriptions have a standard length (*i.e.*, 30-days) and are prescribed on different days, the individual is required to pick up prescriptions at various times during the month. Alignment of dispensing could improve medication adherence by individuals living with chronic diseases.

This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs. Specifically, GAO would identify common characteristics of programs and assess their impact on medication adherence, patient outcomes, and patient satisfaction. GAO would also assess the extent to which Medicare rules support medication synchronization and whether there are barriers to such programs in Medicare.

Section 603. GAO Study and Report on Impact of Obesity Drugs on Patient Health and Spending

Obesity is a serious problem that is often directly related to or exacerbates chronic diseases. Prescription drug treatments may be an effective policy intervention, but more information is needed to better understand the impact on quality and overall costs to the Medicare program. Historically, Medicare Part D has not covered drugs used for weight loss or gain, or for cosmetic purposes. Some Medicare Advantage prescription drug plans (MA-PDs) are permitted to cover these drugs as a supplemental benefit.

This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the impact of the use of obesity drugs on patient health and spending. Specifically, GAO would look at obesity drug utilization in Medicare and other payer programs, identify physician prescribing attitudes, assess drug adherence, and maintain weight loss. GAO would also identify the impact of obesity drugs on patient health outcomes, on other services furnished, and health spending.

Section 604. HHS Study on Long-Term Risk Factors for Chronic Conditions among Medicare Beneficiaries

This section would require the Secretary to submit a report to Congress within 18 months of the date of enactment that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions. The study would include barriers to collecting and analyzing the information needed to conduct this evaluation and make legislative and regulatory recommendations for removing such barriers.

TITLE VII – OFFSETS

Section 701. Medicare Improvement Fund

This section would eliminate the funding in the Medicare Improvement Fund.

Section 702. Medicaid Improvement Fund

This section would eliminate the funding in the Medicaid Improvement Fund.