I

113TH CONGRESS
2D SESSION

H. R. 3890

To amend title XVIII of the Social Security Act to establish a Medicare Better Care Program to provide integrated care for Medicare beneficiaries with chronic conditions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 15, 2014

Mr. PAULSEN (for himself and Mr. WELCH) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to establish a Medicare Better Care Program to provide integrated care for Medicare beneficiaries with chronic conditions, and for other purposes.

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 "Better Care, Lower Cost Act".
6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Medicare Better Care Program.
Sec. 4. Chronic special needs plans.
Sec. 5. Improvements to welcome to Medicare visit and annual wellness visits.
Sec. 6. Chronic care innovation centers.
Sec. 7. Curricula requirements for direct and indirect graduate medical education payments.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) The field of medicine is ever-evolving and
4 we need a highly skilled, team-oriented workforce
5 that can meet the health care needs of today as well
6 as the health care challenges of tomorrow.

7 (2) The Medicare program should recognize the
8 growing uses and benefits of health technology in de-
9 livering quality and cost-efficient care by encour-
10 aging the use of telemedicine and remote patient
11 monitoring.

12 **SEC. 3. MEDICARE BETTER CARE PROGRAM.**

13 (a) IN GENERAL.—Title XVIII of the Social Security
14 Act (42 U.S.C. 1395 et seq.) is amended by adding at
15 the end the following new section:

16 ‘‘MEDICARE BETTER CARE PROGRAM

17 ‘‘SEC. 1899B. (a) ESTABLISHMENT.—

18 ‘‘(1) IN GENERAL.—Not later than January 1,
19 2017, the Secretary shall establish an integrated
20 chronic care delivery program (in this section re-
21 ferred to as the ‘program’) that promotes account-

1 ability and better care management for chronically
2 ill patient populations and coordinates items and
3 services under parts A, B, and D, while encouraging
4 investment in infrastructure and redesigned care
5 processes that result in high quality and efficient
6 service delivery for the most vulnerable and costly
7 populations. The program shall—

8 ‘‘(A) focus on long-term cost containment
9 and better overall health of the Medicare popu-
10 lation by implementing through qualified BCPs
11 (as described in paragraph (2)(A)) strategies
12 that prevent, delay, or minimize the progression
13 of illness or disability associated with chronic
14 conditions; and

15 ‘‘(B) include the program elements de-
16 scribed in paragraph (2).

17 ‘‘(2) PROGRAM ELEMENTS.—The following pro-
18 gram elements are described in this paragraph:

19 ‘‘(A) A health plan or group of providers
20 of services and suppliers, or a health plan work-
21 ing with such a group, that the Secretary cer-
22 tifies in accordance with subsection (e) as meet-
23 ing criteria developed by the Secretary to recog-
24 nize the challenges of managing a chronically ill
25 population, including patient satisfaction and

1 engagement, quality measurement developed
2 specifically for a chronically ill population, and
3 effective use of resources and providers, may
4 manage and coordinate care for BCP eligible
5 individuals through an integrated care network,
6 or Better Care Program (referred to in this sec-
7 tion as a 'qualified BCP'). A group of providers
8 of services and suppliers described in the pre-
9 ceding sentence may also be participating in an-
10 other alternative payment model (as defined in
11 subsection (k)).

12 "(B) Payments to a qualified BCP shall be
13 made in accordance with subsection (g).

14 "(C) Implementation of the program shall
15 focus on physical, behavioral, and psychosocial
16 needs of BCP eligible individuals.

17 "(D) Quality and cost containment are
18 considered interdependent goals of the program.

19 "(E) The calculation of long-term cost sav-
20 ings is dependent on qualified BCPs delivering
21 the full continuum of covered primary, post-
22 acute care, and social services using capitated
23 financing.

24 "(3) TARGETED PARTICIPATION.—

1 "(A) IN GENERAL.—In certifying qualified
2 BCPs throughout the country, the Secretary
3 shall give priority to areas—
4 "(i) that do not have a concentration
5 of accountable care organizations under
6 section 1899; and
7 "(ii) with a high burden of chronic
8 conditions.
9 "(B) INITIAL REQUIREMENT.—In the first
10 5 years of the program, at least 50 percent of
11 all new qualified BCPs certified nationwide by
12 the Secretary shall be from counties or regions,
13 as determined by the Secretary, where the prev-
14 alence of the most costly chronic conditions is
15 at or greater than 125 percent of the national
16 average.
17 "(C) RESTRICTING THE NUMBER OF PAR-
18 TICIPATING BCPS.—
19 "(i) IN GENERAL.—The Secretary
20 shall take into account geography, urban
21 and rural designations, and the population
22 case mix that will be served, when selecting
23 BCPs for participation.
24 "(ii) LIMITATION DURING THE FIRST
25 FOUR PROGRAM YEARS.—During the first

1 four years of the program, the total num-
2 ber of qualified BCPs certified by the Sec-
3 retary shall not exceed 250.
4 "(iii) NO LIMITATION DURING FIFTH
5 AND SUBSEQUENT PROGRAM YEARS.—Dur-
6 ing the fifth year and any subsequent year
7 of the program, the Secretary may certify
8 any BCP that meets the requirements to
9 be certified as a qualified BCP.
10 "(4) ALIGNMENT WITH APPROVED STATE PLAN
11 WAIVERS.—In certifying qualified BCPs, the Sec-
12 retary shall ensure alignment with other approved
13 waivers of State plans under title XIX.
14 "(b) DEFINITION OF BCP ELIGIBLE INDIVIDUALS.—
15 "(1) DEFINITION.—For purposes of this sec-
16 tion, the term 'BCP eligible individual' means an in-
17 dividual who—
18 "(A) is entitled to benefits under part A
19 and enrolled under parts B and D, including an
20 individual who is enrolled in a Medicare Advan-
21 tage plan under part C, an eligible organization
22 under section 1876, or a PACE program under
23 section 1894; and
24 "(B) is medically complex given the preva-
25 lence of chronic disease that actively and per-

1 sistently affects their health status, and absent
2 appropriate care interventions, causes them to
3 be at enhanced risk for hospitalization, limita-
4 tions on activities of daily living, or other sig-
5 nificant health outcomes.

6 "(2) DUAL ELIGIBLE INDIVIDUALS.—An indi-
7 vidual who is dually eligible for Medicare and Med-
8 icaid shall not be excluded from enrolling in a quali-
9 fied BCP. Dually eligible beneficiaries enrolled in a
10 qualified BCP will see the full scope of their benefits
11 under this title and title XIX (other than long-term
12 care) managed by the qualified BCP.

13 "(c) NOTIFICATION AND ENROLLMENT.—

14 "(1) NOTIFICATION.—Not later than October 1
15 of each year, the Secretary shall use all available
16 tools, including the notice mailed annually under
17 section 1804(a) and State health insurance assist-
18 ance programs, to notify BCP eligible individuals of
19 qualified BCPs in their area for the upcoming plan
20 year. Such information shall also be easily accessible
21 on the Internet website of the Centers for Medicare
22 & Medicaid Services.

23 "(2) ENROLLMENT.—The Secretary shall estab-
24 lish procedures under which BCP eligible individuals

1 may voluntarily enroll in a qualified BCP at the fol-
2 lowing times:
3 ''(A) During the annual, coordinated elec-
4 tion period under section 1851(e)(3)(B).
5 ''(B) During or following (for a length of
6 time determined by the Secretary)—
7 ''(i) an initial preventive physical ex-
8 amination (as defined in section
9 1861(ww)); or
10 ''(ii) any subsequent visit where a
11 chronic condition is identified or a previous
12 condition is identified as having escalated
13 to the level of a chronic condition.
14 ''(d) PATIENT ASSESSMENT.—
15 ''(1) STANDARDIZED FUNCTIONAL AND HEALTH
16 RISK ASSESSMENT.—
17 ''(A) MINIMUM GUIDELINES.—Not later
18 than January 1, 2016, the Secretary shall pub-
19 lish minimum guidelines for qualified BCPs to
20 furnish to enrollees a health information tech-
21 nology-compatible, standardized, and multi-
22 dimensional risk assessment that—
23 ''(i) assesses and quantifies the med-
24 ical, psychosocial, and functional status of
25 an enrollee; and

1 "(ii) includes a mechanism to deter-
2 mine the level of patient activation and
3 ability to engage in self-care of an enrollee.
4 "(B) UPDATING.—Not less frequently than
5 once every 3 years, the Secretary shall, through
6 rulemaking, update such minimum guidelines to
7 reflect new clinical standards and practices, as
8 appropriate.
9 "(2) INDIVIDUAL PATIENT-CENTERED CHRONIC
10 CARE PLAN.—
11 "(A) MODEL PLAN.—Not later than Janu-
12 ary 1, 2016, the Secretary shall publish min-
13 imum guidelines for qualified BCPs to develop
14 individual patient-centered chronic care plans
15 for enrollees. Such a plan shall—
16 "(i) allow health professionals to in-
17 corporate the medical, psychosocial, and
18 functional components identified in the
19 risk assessment described in paragraph
20 (1)(A)(i);
21 "(ii) provide a framework that can be
22 easily integrated into electronic health
23 records, allowing clinicians to make timely,
24 accurate, evidence-based decisions at the
25 point of care; and

1 "(iii) allow for the provider to describe
2 how services will be provided to the en-
3 rollee.

4 "(B) USE OF TECHNOLOGY FOR PATIENT
5 SELF CARE.—

6 "(i) IN GENERAL.—Whenever appro-
7 priate, the individual patient-centered
8 chronic care plan of an enrollee shall in-
9 clude the use of technologies that enhance
10 communication between patients, pro-
11 viders, and communities of care, such as
12 telehealth, remote patient monitoring,
13 Smartphone applications, and other such
14 enabling technologies, that promote patient
15 engagement and self care while maintain-
16 ing patient safety.

17 "(ii) COORDINATION AND DEVELOP-
18 MENT OF STREAMLINED PATHWAY.—The
19 Secretary shall work with the Office of the
20 National Coordinator for Health Informa-
21 tion Technology and the Department of
22 Health and Human Services Chief Tech-
23 nology Officer to develop a streamlined
24 pathway for the use of mobile applications
25 and communications devices that effec-

1 tively enhance the experience of the patient
2 while maintaining patient safety and cost-
3 effectiveness. Such pathway shall not du-
4 plicate existing efforts.

5 "(e) QUALIFIED BCP PROVIDERS.—

6 "(1) CRITERIA.—

7 "(A) IN GENERAL.—Any health plan, pro-
8 vider of services, or group of providers of serv-
9 ices and suppliers, who agrees to meet the re-
10 quirements described in paragraph (2) and is
11 specified in subparagraph (C) may form a mul-
12 tidisciplinary team of health professionals to be
13 certified as a qualified BCP. Those providers
14 may also choose to partner with a qualified in-
15 surer to become a qualified BCP.

16 "(B) NO PREEMPTION OF STATE LICEN-
17 SURE LAWS.—Nothing in this section shall pre-
18 empt State licensure laws.

19 "(C) GROUPS OF PROVIDERS AND SUP-
20 PLIERS SPECIFIED.—

21 "(i) IN GENERAL.—As determined ap-
22 propriate by the Secretary, the following
23 health plans, providers of services, or
24 groups of providers of services and sup-
25 pliers, that meet the criteria described in

1 clause (ii) may be certified as qualified
2 BCPs under the program:
3 "(I) Health professionals acting
4 as part of a multidisciplinary team.
5 "(II) Networks of individual
6 practices of health professionals that
7 may include community health cen-
8 ters, Federally qualified health cen-
9 ters, rural health clinics, and partner-
10 ships or affiliations with hospitals.
11 "(III) Health plans that meet ap-
12 propriate network adequacy stand-
13 ards, as determined by the Secretary,
14 and that include providers with expe-
15 rience and interest in managing a
16 population with chronic conditions.
17 "(IV) Independent health profes-
18 sionals partnering with an inde-
19 pendent risk manager.
20 "(V) Such other groups of pro-
21 viders of services or suppliers as the
22 Secretary determines appropriate.
23 "(ii) CRITERIA DESCRIBED.—The fol-
24 lowing criteria are described in this clause:

1 "(I) Demonstrated capacity to
2 manage the full continuum of care
3 (other than long-term care) for the
4 specialized population of BCP eligible
5 individuals.

6 "(II) Having a high rate of Medi-
7 care customer satisfaction, when ap-
8 plicable, or partnering with providers
9 of services or suppliers with such a
10 demonstrated high satisfaction rate.

11 "(2) REQUIREMENTS.—A qualified BCP shall
12 meet the following requirements:

13 "(A) The qualified BCP shall be account-
14 able for the quality, cost, and overall care of en-
15 rolled BCP eligible individuals and agree to be
16 at financial risk for that enrolled population. A
17 qualified BCP shall be established with the ob-
18 jective of serving BCP eligible individuals.

19 "(B) The qualified BCP shall be respon-
20 sible for the full continuum of care (other than
21 long-term care) for enrollees. This continuum
22 shall include medical care, skilled nursing and
23 home health services, behavioral health care,
24 and social services. The qualified BCP may not
25 actively restrict an enrollee's access to providers

1 based on a practitioner's license or medical spe-
2 cialty based on cost alone.

3 "(C) The qualified BCP shall primarily
4 consist of a care team tasked with responding
5 to, treating, and actively supporting the needs
6 of BCP eligible individuals. The care team shall
7 also develop a care plan for each eligible BCP
8 enrollee and use it as a tool to execute effective
9 care management and transitions.

10 "(D) The qualified BCP shall include phy-
11 sicians, nurse practitioners, registered nurses,
12 social workers, pharmacists, and behavioral
13 health providers who commit to caring for BCP
14 eligible individuals.

15 "(E) The qualified BCP shall enter into an
16 agreement with the Secretary to participate in
17 the program under this section for not less than
18 a 3-year period.

19 "(F) The qualified BCP shall include ade-
20 quate numbers of primary care and other rel-
21 evant professionals that can effectively care for
22 the number of BCP eligible individuals enrolled
23 in the qualified BCP.

24 "(G) The qualified BCP shall provide the
25 Secretary with such information regarding

1 qualified BCP professionals participating in the
2 qualified BCP necessary to support the enroll-
3 ment of BCP eligible individuals in a qualified
4 BCP, including evidence relating to high pa-
5 tient satisfaction when available, the implemen-
6 tation of quality reporting and other reporting
7 requirements, and evidence to support a deter-
8 mination of capitated payments in accordance
9 with subsection (g).

10 "(H) The qualified BCP shall have in
11 place a structure that includes clinical and ad-
12 ministrative systems, including health informa-
13 tion technology, that supports the integration of
14 services and providers across sites of care.

15 "(I) The qualified BCP may develop a col-
16 laborative partnership that supports the mission
17 of the BCP with each of the following:

18 "(i) A regional or national Chronic
19 Care Innovation Center under section 6 of
20 the Better Care, Lower Cost Act.

21 "(ii) A regional or national Center of
22 Innovation (COIN) of the Department of
23 Veterans Affairs Health Services Research
24 and Development Service to identify and
25 implement best practices—

1 "(I) to increase access to, and
2 implementation of, prevention and
3 wellness tools;
4 "(II) to integrate physical and
5 behavior health care with social serv-
6 ices;
7 "(III) to promote evidence-based
8 medicine and patient engagement;
9 "(IV) to coordinate care across
10 providers and care settings;
11 "(V) to allow more patients to be
12 cared for in their homes and commu-
13 nities;
14 "(VI) to reduce hospital readmis-
15 sions;
16 "(VII) to improve health out-
17 comes for patients with chronic condi-
18 tions; and
19 "(VIII) to report on quality im-
20 provement and cost measures.
21 "(iii) A regional or national Tele-
22 health Resource Center of the Health Re-
23 sources and Services Administration
24 (HRSA) Office for the Advancement of
25 Telehealth to create an interactive, online

1 resource for qualified BCP professionals
2 who may need additional training or assist-
3 ance in managing the needs of a complex
4 patient population, including—
5 "(I) continuing training and edu-
6 cation and mentoring for qualified
7 BCP professionals at any level of li-
8 censure;
9 "(II) clinician support for com-
10 plex patients by an expert panel;
11 "(III) remote access to regional,
12 national, and international experts in
13 the field;
14 "(IV) forums for best practices
15 to be discussed among qualified BCP
16 professionals;
17 "(V) inter-professional education
18 supporting optimal communication be-
19 tween members of a chronic care
20 team; and
21 "(VI) continuing training on the
22 use of telehealth, remote patient mon-
23 itoring, and other such enabling tech-
24 nologies.

1 "(J) The qualified BCP shall demonstrate
2 to the Secretary that it meets person-
3 centeredness criteria specified by the Secretary
4 in collaboration with accreditation organiza-
5 tions, including the use of patient and caregiver
6 assessments and the use of individual patient-
7 centered chronic care plans for each enrollee (as
8 described in subsection (d)(2)).
9 "(K) The qualified BCP may identify and
10 respond to unique cultural, social, and economic
11 needs of a community that impact access to,
12 and quality of, healthcare.
13 "(L) The qualified BCP shall provide care
14 across settings, including in the home as need-
15 ed.
16 "(M) The qualified BCP shall demonstrate
17 financial solvency (as determined by the Sec-
18 retary).
19 "(N) The qualified BCP shall demonstrate
20 the ability to partner with providers of social
21 and behavioral health services within the com-
22 munity.
23 "(O) The qualified BCP shall engage in
24 continuing education on chronic care, on an on-
25 going basis (as determined necessary by the

1 Chronic Care Innovation Center under the part-
2 nership under subparagraph (J)(i)), in collabo-
3 ration with the Agency for Healthcare Research
4 and Quality, the Health Resources and Services
5 Administration, and the Department of Vet-
6 erans Affairs.

7 "(f) IMPLEMENTING VALUE-BASED INSURANCE DE-
8 SIGN.—

9 "(1) IN GENERAL.—

10 "(A) ELECTION.—A qualified BCP may
11 elect to provide value-based Medicare coverage
12 in accordance with this subsection.

13 "(B) INCLUSION OF ORIGINAL MEDICARE
14 FEE-FOR-SERVICE PROGRAM BENEFITS.—Sub-
15 ject to subparagraph (C), enrollees in a quali-
16 fied BCP that elects to provide value-based
17 Medicare coverage under this subsection shall
18 receive such coverage that includes items and
19 services for which benefits are available under
20 parts A and B to individuals entitled to benefits
21 under part A and enrolled under part B, with
22 cost-sharing for those items and services as de-
23 scribed in subparagraph (C).

24 "(C) COST-SHARING.—Cost-sharing de-
25 scribed in this subparagraph, with respect to an

1 enrollee in a qualified BCP that makes such an
2 election, is varied cost-sharing approved by the
3 Secretary to incentivize the use of high-value,
4 high-quality services that have been clinically
5 proven to benefit BCP eligible individuals.

6 ‘‘(D) CHANGES IN COVERAGE.—The Sec-
7 retary, in consultation with experts in the field,
8 shall establish a process for qualified BCPs to
9 submit value-based Medicare coverage changes
10 that encourage and incentivize the use of evi-
11 dence-based practices that will drive better out-
12 comes while ensuring patient protections and
13 access are maintained.

14 ‘‘(E) NO REQUIREMENT FOR COVERAGE OF
15 LONG-TERM CARE SERVICES.—In no case shall
16 a qualified BCP be required to provide to en-
17 rollees coverage for long-term care services.

18 ‘‘(2) QUALIFIED BCP PARTICIPATION.—

19 ‘‘(A) CONTINUED ACCESS.—Subject to
20 subparagraph (B), enrollees in a qualified BCP
21 shall continue to have access to all providers of
22 services and suppliers under this title.

23 ‘‘(B) NO APPLICATION OF VARIED COST-
24 SHARING FOR NONPARTICIPATING PROVIDERS
25 OF SERVICES AND SUPPLIERS.—

1 "(i) IN GENERAL.—The varied cost-
2 sharing under paragraph (1)(B) shall only
3 apply to items and services furnished by
4 qualified BCP professionals of a qualified
5 BCP that makes an election under para-
6 graph (1). In the case where items and
7 services are furnished by a provider of
8 services or supplier who is not such a
9 qualified BCP professional, the cost-shar-
10 ing applicable for those items and services
11 will be the cost-sharing as required under
12 parts A and B, or an actuarially equivalent
13 level of cost-sharing as determined by the
14 Secretary.
15 "(ii) NOTIFICATION.—A BCP eligible
16 individual shall be notified and counseled
17 prior to the time of enrollment on potential
18 changes in out-of-pocket costs that may
19 occur if care is provided by a provider of
20 services or supplier that is not a qualified
21 BCP professional.
22 "(3) LIMITATIONS ON OUT-OF-POCKET EX-
23 PENSES OUTSIDE A QUALIFIED BCP.—
24 "(A) IN GENERAL.—Out-of-pocket costs,
25 including individual beneficiary copayments,

1 with respect to items and services furnished by
2 a provider of services or supplier who is not a
3 qualified BCP professional shall not exceed
4 what would otherwise have been paid with re-
5 spect to the item or service under the original
6 Medicare fee-for-service program under parts A
7 and B for the same services or an actuarially
8 equivalent level of cost-sharing as determined
9 by the Secretary, or, in the case of a dual eligi-
10 ble individual, under the Medicaid program
11 under title XIX.

12 "(B) PROHIBITION ON COVERAGE OF
13 COST-SHARING FOR CERTAIN ITEMS AND SERV-
14 ICES FURNISHED TO AN ENROLLEE OUTSIDE
15 OF A QUALIFIED BCP UNDER MEDIGAP POLI-
16 CIES.—For provisions relating to prohibition on
17 coverage of cost-sharing for items and services
18 (other than emergent services, as defined by the
19 Secretary) furnished to an enrollee outside of a
20 qualified BCP under Medigap policies, see sec-
21 tion 1882(z).

22 "(4) PRESCRIPTION DRUG COVERAGE.—

23 "(A) DRUG PLAN OPTION.—

24 "(i) IN GENERAL.—A health plan cer-
25 tified as a qualified BCP may provide en-

1 rollees with a drug plan option specifically
2 designed to reflect the medication needs of
3 enrollees.

4 "(ii) APPLICATION OF PART D PROVI-
5 SIONS.—

6 "(I) IN GENERAL.—Except as
7 otherwise provided in this section, the
8 provisions of part D shall apply to a
9 drug plan option offered by a qualified
10 BCP under clause (i) in the same
11 manner as such provisions apply to a
12 prescription drug plan offered by a
13 PDP sponsor under such part.

14 "(II) LIMITATION OF ENROLL-
15 MENT.—A qualified BCP offering
16 such a drug plan option may limit en-
17 rollment in the drug plan option to
18 enrollees in the qualified BCP.

19 "(III) WAIVER.—The Secretary
20 may waive such provisions of part D
21 as are necessary to carry out this sec-
22 tion.

23 "(B) AGREEMENT WITH PRESCRIPTION
24 DRUG PLANS.—A qualified BCP managed by a
25 group of providers of services may enter into an

1 agreement with a PDP sponsor of a prescrip-
2 tion drug plan under part D to establish and
3 encourage individuals enrolled in the qualified
4 BCP to enroll in a prescription drug plan under
5 such part that is better suited to the needs of
6 chronically ill individuals.

7 "(C) LIMITATION.—A drug plan option of-
8 fered by a qualified BCP under subparagraph
9 (A)(i) shall not have the authority to increase
10 out-of-pocket limits otherwise applicable under
11 part D.

12 "(g) PAYMENTS AND TREATMENT OF SAVINGS.—

13 "(1) PAYMENTS TO QUALIFIED BCPS ON A
14 CAPITATED BASIS.—

15 "(A) IN GENERAL.—In the case of a quali-
16 fied BCP under this section, the Secretary shall
17 make prospective monthly payments of a capita-
18 tion amount for each BCP eligible individual
19 enrolled in the qualified BCP in the same man-
20 ner and from the same sources as payments are
21 made to a Medicare Advantage organization
22 under section 1853. Such payments shall be
23 subject to adjustment in the manner described
24 in section 1853(a)(2) or section 1876(a)(1)(E),
25 as the case may be.

1 "(B) CAPITATION AMOUNT.—The capita-
2 tion amount to be applied under this paragraph
3 for a qualified BCP for each enrollee for a year
4 shall be 1/12 of the benchmark rate under sub-
5 paragraph (C)(ii) for the year (or the relevant
6 rate under subparagraph (C)(i) for the first
7 year of the program under this section) (re-
8 ferred to in this paragraph as the 'per member
9 per month payment'), as adjusted under clause
10 (iii).

11 "(C) DETERMINING THE RATE USING RISK
12 RELEVANT CONTROL GROUP.—

13 "(i) RELEVANT RATE.—

14 "(I) IDENTIFICATION OF BENE-
15 FICIARY GROUPING.—Using claims
16 data, the Secretary shall identify a
17 group of beneficiaries who have simi-
18 lar health risk characteristics, and
19 have sought care in the same county,
20 multi-county, or State level (as deter-
21 mined appropriate by the Secretary to
22 establish a payment area) to the pop-
23 ulation the qualified BCP is tasked
24 with serving. To the extent feasible
25 for a statistically valid control group,

1 the health risk of such group shall re-
2 flect social characteristics, such as in-
3 come, as well as medical risk.

4 ‘‘(II) DETERMINATION OF REL-
5 EVANT RATE.—The per capita spend-
6 ing amounts under this title and, as
7 appropriate, title XIX, of the group of
8 beneficiaries identified under sub-
9 clause (I) shall determine the ‘rel-
10 evant rate’ that will serve as the basis
11 of the benchmark for participating
12 qualified BCPs.

13 ‘‘(ii) BENCHMARK RATE.—The Sec-
14 retary shall establish the benchmark rate
15 for a qualified BCP service area for each
16 year of the program by updating the rel-
17 evant rate determined under clause (i) with
18 the projected change in per capita spend-
19 ing for the group of beneficiaries identified
20 under clause (i)(I) for the payment area
21 described in such clause, as determined by
22 the Chief Actuary of the Centers for Medi-
23 care & Medicaid Services.

24 ‘‘(iii) ADJUSTMENT FOR HEALTH STA-
25 TUS.—

1 "(I) COMPARISON OF HEALTH
2 STATUS.—The Secretary shall estab-
3 lish a risk score mechanism to com-
4 pare the health status of an enrollee
5 in a qualified BCP to the average
6 health risk of group of beneficiaries
7 identified under clause (i)(I).

8 "(II) INCLUSION OF NUMBER OF
9 CONDITIONS.—The Secretary shall
10 provide that a risk score under the
11 mechanism under this clause, with re-
12 spect to an individual, includes an in-
13 dicator for the number of chronic con-
14 ditions with which the individual has
15 been diagnosed.

16 "(III) USE OF 2 YEARS OF DIAG-
17 NOSIS DATA.—The Secretary shall en-
18 sure that such risk score, with respect
19 to an individual reflects not less than
20 2 years of diagnosis data, to the ex-
21 tent available.

22 "(IV) ADJUSTMENT FOR HEALTH
23 STATUS.—The per member per month
24 payment to the qualified BCP for
25 each enrollee shall be adjusted de-

1 pending on how the individual risk
2 profile of the enrollee compares to the
3 average health status of such group of
4 beneficiaries. If an enrollee has a risk
5 profile that is not as severe as the av-
6 erage health status of such group of
7 beneficiaries, then the per member per
8 month shall be decreased to reflect the
9 'healthier' status of the enrollee. If an
10 enrollee has a risk profile that is more
11 severe, then the per member per
12 month payment to the qualified BCP
13 shall be increased to reflect the more
14 acutely ill status of the enrollee.
15 "(D) SHARED RISK PAYMENTS FOR CER-
16 TAIN QUALIFIED BCPS DURING FIRST 3 YEARS
17 OF THE PROGRAM.—
18 "(i) IN GENERAL.—This subpara-
19 graph shall only apply to qualified BCPs
20 offered by a group of providers of services
21 and suppliers during the first 3 years of
22 the program under this section.
23 "(ii) SHARING OF RISK TO ALLEVIATE
24 OUTLIERS.—The Secretary shall determine
25 shared risk payments and recoupments

1 under this subparagraph for a qualified
2 BCP described in clause (i) as follows:
3 "(I) DETERMINATION OF GAIN
4 OR LOSS.—The Secretary shall, for
5 each of the first 3 years of the pro-
6 gram under this section, determine
7 the percentage of gain or loss for the
8 qualified BCP in providing benefits to
9 enrollees under this section.
10 "(II) GAIN OR LOSS GREATER
11 THAN 5 PERCENT.—If the Secretary
12 determines the qualified BCP has a
13 gain or loss for the year of greater
14 than 5 percent, the qualified BCP
15 shall bear 100 percent of the risk or
16 reward of such loss or gain.
17 "(III) GAIN OR LOSS OF NOT
18 LESS THAN 2 AND NOT GREATER
19 THAN 5 PERCENT.—If the Secretary
20 determines the qualified BCP has a
21 gain or loss for the year of not less
22 than 2 percent but not greater than 5
23 percent—
24 "(aa) the qualified BCP
25 shall bear 80 percent of the risk

1 or reward, as applicable, of such
2 loss or gain; and
3 "(bb) the Secretary shall
4 bear 20 percent of the risk or re-
5 ward, as applicable, of such loss
6 or gain.
7 "(IV) GAIN OR LOSS BETWEEN 0
8 AND 2 PERCENT.—If the Secretary de-
9 termines the qualified BCP has a gain
10 or loss for the year of greater than 0
11 percent but less than 2 percent—
12 "(aa) the qualified BCP
13 shall bear 50 percent of the risk
14 or reward, as applicable, of such
15 loss or gain; and
16 "(bb) the Secretary shall
17 bear 50 percent of the risk or re-
18 ward, as applicable, of such loss
19 or gain.
20 "(iii) PROVISION OF INFORMATION.—
21 A qualified BCP shall provide to the Sec-
22 retary such information as the Secretary
23 determines is necessary to carry out this
24 subparagraph.

1 ‘‘(E) BID SUBMISSION.—Beginning with
2 the fourth year of the program, a qualified
3 BCP shall submit a bid for participation in the
4 program for the year that reflects the experi-
5 ence of the qualified BCP—
6 ‘‘(i) in managing the care of the en-
7 rolled population; and
8 ‘‘(ii) in managing such care given the
9 relevant rate determined under subpara-
10 graph (C).
11 ‘‘(F) QUALITY BONUS SYSTEM.—
12 ‘‘(i) IN GENERAL.—The Secretary
13 shall establish a quality bonus system
14 whereby the Secretary distributes bonus
15 payments to qualified BCPs that meet the
16 requirements described in clause (iii) and
17 other standards specified by the Secretary,
18 which may include a focus on quality
19 measurement and improvement, delivering
20 patient-centered care, and practicing in in-
21 tegrated health systems, including training
22 in community-based settings. In developing
23 such standards, the Secretary shall collabo-
24 rate with relevant stakeholders, including
25 program accrediting bodies, certifying

1 boards, training programs, health care or-
2 ganizations, health care purchasers, and
3 patient and consumer groups.

4 "(ii) DETERMINATION OF QUALITY
5 BONUSES.—Quality bonuses to the BCP
6 shall be based on a comparison of the qual-
7 ity of care provided by the qualified BCP
8 to enrollees to the quality of care provided
9 to beneficiaries not enrolled in a qualified
10 BCP or a Medicare Advantage plan under
11 part C in the same region. For not less
12 than the first 5 years of the program
13 under this section, quality measures for
14 the geographic region shall be based on
15 local standards of care, and not on a na-
16 tional standard. For subsequent years, ap-
17 propriate national standards shall be con-
18 sidered for inclusion in the comparison of
19 the quality of care under this subpara-
20 graph.

21 "(iii) REQUIREMENTS.—A qualified
22 BCP is eligible for quality bonuses under
23 this subparagraph if—

1 “(I) the qualified BCP meets
2 quality performance standards under
3 subsection (h)(3); and
4 “(II) the qualified BCP meets
5 the requirements under subsection
6 (e)(2).
7 “(h) QUALITY AND OTHER REPORTING REQUIRE-
8 MENTS.—
9 “(1) IN GENERAL.—The Secretary shall develop
10 and implement, with assistance and input of relevant
11 experts in the field and the National Strategy for
12 Quality Improvement in Health Care, appropriate
13 measures for BCP eligible individuals. The Secretary
14 shall determine appropriate measures under this title
15 and title XIX to assess the quality of care furnished
16 by a qualified BCP, as well as those measures that
17 are no longer appropriate and shall be removed from
18 use. Such measures shall include measures—
19 “(A) of clinical processes and outcomes;
20 “(B) of patient and, where practicable,
21 caregiver experience of care, including measure-
22 ment that enhances patient activation and en-
23 gagement;

1 "(C) of utilization (such as rates of hos-
2 pital admissions for ambulatory care sensitive
3 conditions);
4 "(D) of care coordination, management,
5 and transitions; and
6 "(E) that appropriately align with the Na-
7 tional Strategy for Quality Improvement in
8 Health Care.
9 The Secretary may use existing measures under this
10 title, title XIX, or any other health care program, as
11 appropriate, under this paragraph.
12 "(2) REPORTING REQUIREMENTS.—A qualified
13 BCP shall submit data in a form and manner speci-
14 fied by the Secretary which is not overly burdensome
15 to the qualified BCP, on measures the Secretary de-
16 termines necessary for the qualified BCP to report
17 in order to evaluate the quality of care furnished by
18 the qualified BCP. Such data reporting shall empha-
19 size 'patient-centered measurement' and may include
20 the functional status of patients, case management
21 and care transitions across health care settings, in-
22 cluding hospital discharge planning and post-hospital
23 discharge follow-up by qualified BCP professionals,
24 as the Secretary determines appropriate.

1 "(3) QUALITY PERFORMANCE STANDARDS.—
2 The Secretary shall establish quality performance
3 standards to assess the quality of care furnished by
4 qualified BCPs. The Secretary shall seek to improve
5 the quality of care furnished by qualified BCPs over
6 time by specifying higher standards, new measures,
7 or both for purposes of assessing such quality of
8 care. The Secretary shall also include a process for
9 retiring measures that are no longer adequately con-
10 tributing to improving standards of care at the
11 greatest possible value.

12 "(4) OTHER REPORTING REQUIREMENTS AND
13 CALL FOR ALIGNMENT.—The Secretary shall, as the
14 Secretary determines appropriate, incorporate and
15 align reporting requirements and incentive payments
16 related to the physician quality reporting system
17 under section 1848, including those related to re-
18 porting on quality measures under subsection (m) of
19 that section, reporting requirements under sub-
20 section (o) of that section relating to meaningful use
21 of electronic health records, the establishment of a
22 value-based payment modifier under subsection (p)
23 of that section, and other similar initiatives under
24 that section, and may use alternative criteria than
25 would otherwise apply under section 1848 for deter-

1 mining whether to make such payments to qualified
2 BCP professionals. The incentive payments de-
3 scribed in the preceding sentence shall not be taken
4 into consideration when calculating any payments
5 otherwise made under subsection (g).

6 ''(i) BENEFICIARY PROTECTIONS.—The Secretary
7 shall ensure that, to the extent consistent with this sec-
8 tion, a qualified BCP offers beneficiary protections appli-
9 cable to beneficiaries under this title and, as applicable,
10 title XIX.

11 ''(j) PAYMENT OF MEDICARE COST-SHARING FOR
12 DUAL ELIGIBLE INDIVIDUALS.—In the case of a dual eli-
13 gible individual enrolled in a qualified BCP, the Secretary
14 may provide for the payment of medicare cost-sharing (as
15 defined in section 1905(p)(3)) that would otherwise be
16 available under the State plan under title XIX if the indi-
17 vidual was not enrolled in the qualified BCP.

18 ''(k) DEFINITIONS.—In this section:

19 ''(1) ALTERNATIVE PAYMENT MODEL (APM).—
20 The term 'alternative payment model' means any of
21 the following:

22 ''(A) A model under section 1115A (other
23 than a health care innovation award).

24 ''(B) An accountable care organization
25 under section 1899.

1 ‘‘(C) A demonstration under section
2 1866C.
3 ‘‘(D) A demonstration required by Federal
4 law.
5 ‘‘(E) A qualified BCP.
6 ‘‘(2) HOSPITAL.—The term ‘hospital’ means a
7 subsection (d) hospital (as defined in section
8 1886(d)(1)(B)).
9 ‘‘(3) QUALIFIED BCP PROFESSIONAL.—The
10 term ‘qualified BCP professional’ means a certified
11 and licensed professional of medical or behavioral
12 health services that is participating in a qualified
13 BCP.’’.
14 (b) FEDERAL ASSUMPTION OF MEDICAID COSTS FOR
15 FULL BENEFIT DUAL ELIGIBLE INDIVIDUALS ENROLLED
16 IN A QUALIFIED BCP.—Title XIX of the Social Security
17 Act is amended by inserting after section 1943 the fol-
18 lowing new section:
19 ‘‘FEDERAL ASSUMPTION OF MEDICAID COSTS FOR FULL
20 BENEFIT ELIGIBLE INDIVIDUALS ENROLLED IN A
21 QUALIFIED BCP
22 ‘‘SEC. 1944. (a) STATE CONTRIBUTION.—
23 ‘‘(1) IN GENERAL.—The State shall provide for
24 payment to the Secretary for each month in an
25 amount determined under paragraph (2)(A) for each
26 applicable dual eligible BCP enrollee for such State.

1 "(2) STATE CONTRIBUTION AMOUNT.—
2 "(A) IN GENERAL.—Subject to subpara-
3 graph (C), the amount determined under this
4 paragraph for a State for a month in a year is
5 equal to the product described in subparagraph
6 (A) of section 1935(c)(1) for the State for the
7 month, except that the reference in such sub-
8 paragraph to the total number of full-benefit
9 dual eligible individuals shall be deemed a ref-
10 erence to the total number of applicable dual el-
11 igible BCP enrollees.
12 "(B) FORM AND MANNER OF PAYMENT.—
13 The provisions of subparagraphs (B) through
14 (D) of section 1935(c)(1) shall apply to pay-
15 ment by a State to the Secretary under this
16 paragraph in the same manner as such sub-
17 paragraphs apply to payment under section
18 1935(c)(1)(A).
19 "(C) APPLICATION OF DIFFERENT FAC-
20 TORS.—In applying subparagraph (A), the fol-
21 lowing shall be substituted under paragraphs
22 (2) and (3) of section 1935(c):
23 "(i) The base year State Medicaid per
24 capita expenditures for covered part D
25 drugs described in subparagraph (A)(i)(I)

1 of such paragraph (2) shall be deemed to
2 be the per capita expenditures for health
3 care items and services that would apply
4 (including any medicare cost-sharing), with
5 respect to an applicable dual eligible BCP
6 enrollee, if such an individual received ben-
7 efits only under title XVIII (and not the
8 State plan under this title).

9 ''(ii) Any reference to expenditures for
10 covered part D drugs or for prescription
11 drug benefits shall be deemed a reference
12 to the expenditures for health care items
13 and services described in clause (i).

14 ''(iii) Any reference to 2003 or 2004
15 shall be deemed a reference to 2017 or
16 2018, respectively.

17 ''(iv) Any reference to a full-benefit-
18 dual-eligible individual shall be deemed a
19 reference to an applicable dual eligible
20 BCP enrollee.

21 ''(v) The applicable growth factor
22 under section 1935(c)(4) for a year, with
23 respect to a State, shall be the average an-
24 nual percentage change (to that year from
25 the previous year) of the expenditures of

1 the State under the State plan under title
2 XIX.
3 ''(vi) The factor described in section
4 1935(c)(5) is deemed to be 90 percent.
5 ''(3) APPLICABLE DUAL ELIGIBLE BCP EN-
6 ROLLEE.—For purposes of this section, the term
7 'applicable dual eligible BCP enrollee' means, with
8 respect to a State, an individual described in sub-
9 paragraph (A)(ii) of section 1935(c)(6) (taking into
10 account the application of subparagraph (B) of such
11 section) for such State who is enrolled in a qualified
12 BCP under section 1899B. Such term includes, in
13 the case of medical assistance for medicare cost-
14 sharing under a State plan under this title, an indi-
15 vidual who is a qualified medicare beneficiary (as de-
16 fined in section 1905(p)(1)), a qualified disabled and
17 working individual (described in section 1905(s)), an
18 individual described in section 1902(a)(10)(E)(iii),
19 or otherwise entitled to such medicare cost-sharing
20 and who is enrolled in such a qualified BCP.
21 ''(b) COORDINATION OF BENEFITS.—
22 ''(1) MEDICARE AS PRIMARY PAYOR.—In the
23 case of an applicable dual eligible BCP enrollee, not-
24 withstanding any other provision of this title, med-
25 ical assistance is not available under this title for

1 health care items or services (or for any cost-sharing
2 respecting such health care items and services), and
3 the rules under this title relating to the provision of
4 medical assistance for such health care items and
5 services shall not apply. The provision of benefits
6 with respect to such health care items and services
7 shall not be considered as the provision of care or
8 services under the plan under this title. No payment
9 may be made under section 1903(a) for health care
10 items and services for which medical assistance is
11 not available pursuant to this paragraph.

12 ''(2) COVERAGE OF LONG-TERM CARE SERV-
13 ICES.—In the case of medical assistance under this
14 title with respect to coverage of long-term care serv-
15 ices furnished to an applicable dual eligible BCP en-
16 rollee, the State may elect to provide such medical
17 assistance in the manner otherwise provided in the
18 case of individuals who are not full-benefit dual eligi-
19 ble individuals or through an arrangement with such
20 qualified BCP. In no case shall a qualified BCP be
21 required to provide to enrollees coverage of long-
22 term care services.''.

23 (c) STATE MARKETING MATERIALS FOR DUALLY EL-
24 IGIBLE INDIVIDUALS.—

1 (1) STATE PLAN REQUIREMENT.—Section
2 1902(a) of the Social Security Act (42 U.S.C.
3 1396a(a)) is amended—
4 (A) in paragraph (80), by striking ''and''
5 at the end;
6 (B) in paragraph (81), by striking the pe-
7 riod at the end and inserting ''; and''; and
8 (C) by inserting after paragraph (81) the
9 following:
10 ''(82) provide that any marketing materials dis-
11 tributed by the State that are directed at dual eligi-
12 ble individuals (as defined in section 1915(h)(2)(B))
13 include information on qualified BCPs offered under
14 section 1899B.''.
15 (2) EFFECTIVE DATE.—The amendments made
16 by this section shall apply to calendar quarters be-
17 ginning on or after January 1, 2017, without regard
18 to whether or not final regulations to carry out such
19 amendments have been promulgated by such date.
20 (d) PROHIBITION ON COVERAGE OF COST-SHARING
21 FOR CERTAIN ITEMS AND SERVICES FURNISHED TO AN
22 ENROLLEE OUTSIDE OF A QUALIFIED BCP UNDER
23 MEDIGAP POLICIES.—Section 1882 of the Social Security
24 Act (42 U.S.C. 1395ss) is amended by adding at the end
25 the following new subsection:

1 "(z) PROHIBITION ON COVERAGE OF COST-SHARING
2 FOR CERTAIN ITEMS AND SERVICES FURNISHED TO AN
3 ENROLLEE OUTSIDE OF A QUALIFIED BCP AND DEVEL-
4 OPMENT OF NEW STANDARDS FOR MEDICARE SUPPLE-
5 MENTAL POLICIES.—

6 "(1) DEVELOPMENT.—The Secretary shall re-
7 quest the National Association of Insurance Com-
8 missioners to review and revise the standards for
9 benefit packages under subsection (p)(1), taking into
10 account the changes in benefits resulting from the
11 enactment of the Better Care, Lower Cost Act and
12 to otherwise update standards to include the require-
13 ments for cost-sharing described in paragraph (2).
14 Such revisions shall be made consistent with the
15 rules applicable under subsection (p)(1)(E) with the
16 reference to the '1991 NAIC Model Regulation'
17 deemed a reference to the NAIC Model Regulation
18 as published in the Federal Register on December 4,
19 1998, and as subsequently updated by the National
20 Association of Insurance Commissioners to reflect
21 previous changes in law and the reference to 'date
22 of enactment of this subsection' deemed a reference
23 to the date of enactment of the Better Care, Lower
24 Cost Act. To the extent practicable, such revision
25 shall provide for the implementation of revised

1 standards for benefit packages as of January 1,
2 2017.

3 "(2) COST-SHARING REQUIREMENTS.—The
4 cost-sharing requirements described in this para-
5 graph are that, notwithstanding any other provision
6 of law, no medicare supplemental policy may provide
7 for coverage of cost-sharing with respect to items
8 and services (other than emergent services, as de-
9 fined by the Secretary) furnished to an individual
10 enrolled in a qualified BCP under section 1899B by
11 a provider of services or supplier that is not a quali-
12 fied BCP professional (as defined in section
13 1899B(k)).

14 "(3) RENEWABILITY.—The renewability re-
15 quirement under subsection (q)(1) shall be satisfied
16 with the renewal of the revised package under para-
17 graph (1) that most closely matches the policy in
18 which the individual was enrolled prior to such revi-
19 sion.".

20 **SEC. 4. CHRONIC SPECIAL NEEDS PLANS.**

21 Section 1859 of the Social Security Act (42 U.S.C.
22 1395w–28) is amended—

23 (1) in subsection (f)(4)—

1 (A) by striking ''In the case of'' and in-
2 serting ''Subject to subsection (h), in the case
3 of''; and
4 (B) by adding at the end the following
5 flush text:
6 ''Notwithstanding any other provision of this section,
7 on or after January 1, 2014, the Secretary shall es-
8 tablish procedures for the transition of those individ-
9 uals to a Medicare Advantage plan qualified BCP in
10 accordance with subsection (h).''; and
11 (2) by adding at the end the following new sub-
12 section:
13 ''(h) MEDICARE ADVANTAGE PLAN QUALIFIED
14 BCPS.—
15 ''(1) IN GENERAL.—A Medicare Advantage plan
16 that is certified as a qualified BCP (referred to in
17 this subsection as a 'Medicare Advantage plan quali-
18 fied BCP')—
19 ''(A) is deemed to be a specialized MA
20 plan for special needs individuals described in
21 subsection (b)(6)(B)(iii); and
22 ''(B) may enroll such special needs individ-
23 uals.
24 ''(2) SPECIALIZED BENEFIT PACKAGES.—A
25 Medicare Advantage plan qualified BCP shall have

1 the flexibility to offer specialized benefit packages to
2 enrollees described in subsection (b)(6)(B)(iii), con-
3 sistent with the value-based insurance requirements
4 under section 1899B(f).

5 "(3) APPLICATION OF BCP REQUIREMENTS.—A
6 Medicare Advantage plan qualified BCP shall be
7 subject to all requirements applicable to a qualified
8 BCP under section 1899B, including enrollment pe-
9 riods under subsection (c) of that section, applicable
10 criteria relating to network adequacy, requirements
11 with respect to individual patient-centered chronic
12 care plans under subsection (d)(2) of that section,
13 applicable criteria with respect to care management
14 processes, and quality reporting under subsection (h)
15 of that section.

16 "(4) APPLICATION OF PART C REQUIRE-
17 MENTS.—The provisions of this part, including the
18 provisions relating to specialized MA plans for spe-
19 cial needs individuals described in subsection
20 (b)(6)(B)(iii), shall apply to a Medicare Advantage
21 plan qualified BCP to the extent they are consistent
22 with the provisions of section 1899B.".

1 **SEC. 5. IMPROVEMENTS TO WELCOME TO MEDICARE VISIT**
2 **AND ANNUAL WELLNESS VISITS.**

3 (a) WELCOME TO MEDICARE VISIT.—Section
4 1861(ww)(1) of the Social Security Act (42 U.S.C.
5 1395x(ww)(1)) is amended by adding at the end the fol-
6 lowing new sentence: ''In the case of a BCP eligible indi-
7 vidual (as defined in section 1899B(b)), such term in-
8 cludes a standardized functional and health risk assess-
9 ment (as described in section 1899B(d)(1)) furnished by
10 a qualified BCP professional (as defined in section
11 1899B(k)).''.

12 (b) ANNUAL WELLNESS VISIT.—Section
13 1861(hhh)(1) of the Social Security Act (42 U.S.C.
14 1395x(h)(1)) is amended—

15 (1) in subparagraph (A), by striking ''and'' at
16 the end;

17 (2) in subparagraph (B), by striking the period
18 at the end and inserting ''; and''; and

19 (3) by adding at the end the following new sub-
20 paragraph:

21 ''(C) in the case of a BCP eligible indi-
22 vidual (as defined in section 1899B(b)), that in-
23 cludes a standardized functional and health risk
24 assessment (as described in section
25 1899B(d)(1)) furnished by a qualified BCP
26 professional (as defined in section 1899B(k)).''.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 the date that is one year after the date of enactment of
4 this Act.

5 **SEC. 6. CHRONIC CARE INNOVATION CENTERS.**

6 (a) DESIGNATION.—Not later than October 1, 2016,
7 the Secretary, acting through the Agency for Healthcare
8 Research and Quality, shall designate and provide core
9 funding for not less than three Chronic Care Innovation
10 Centers. The Secretary shall develop a process for entities
11 seeking to become a Chronic Care Innovation Center, and
12 shall ensure sufficient geographic representation among
13 those entities selected. The main objectives of such Cen-
14 ters shall include the following:

15 (1) Improving the understanding of how to
16 measure, monitor, and understand quality and effi-
17 ciency for a patient population with substantial dis-
18 ease burden.

19 (2) Rigorously examining alternative and inno-
20 vative systems and strategies for efficiently improv-
21 ing quality and outcomes for common, serious, and
22 chronic illnesses.

23 (3) Developing and applying improved meth-
24 odologies for informing policymakers regarding het-
25 erogeneity in the effectiveness and safety of pro-

1 posed interventions, and assessing barriers to the
2 implementation of high-priority care.
3 (4) Studying organization and management
4 practices that result in higher quality of care.
5 (5) Defining and improving quality of care for
6 patients with the chronic diseases prevalent in pri-
7 mary care settings.
8 (6) Understanding the influence of race, eth-
9 nicity, and cultural factors on access, quality, and
10 outcomes (such as clinical, patient-centered, health
11 care utilization, and costs).
12 (7) Evaluating new technology to enhance ac-
13 cess to, and quality of care (such as telemedicine).
14 (8) Assessing the use of patient self-manage-
15 ment and behavioral interventions as a means of im-
16 proving outcomes for Medicare beneficiaries with
17 complex chronic conditions.
18 (9) Understanding how management of care is
19 affected when patients have multiple chronic condi-
20 tions in which evidence or recommended guidelines
21 are lacking, conflict with, or complicate overall care
22 management.
23 (10) Characterizing coordination of care within
24 and across healthcare systems, including the Depart-
25 ment of Veterans Affairs, the Medicare program

1 under title XVIII of the Social Security Act (42
2 U.S.C. 1395 et seq.), the Medicaid program under
3 title XIX of such Act, and private sector programs
4 for veterans with complex chronic conditions.

5 (b) REQUIREMENTS.—In order to be designated a
6 Chronic Care Innovation Center under this section, each
7 eligible entity must meet the following requirements:

8 (1) Develop and implement a sustained research
9 agenda in the field of chronic care.

10 (2) Collaborate with local schools of public
11 health and universities to carry out its mission.

12 (3) Actively engage in the development of new,
13 best practices for the delivery of care to the chron-
14 ically ill.

15 (4) Actively engage in the development and rou-
16 tine updating of quality measures for the chronically
17 ill.

18 (5) Have the ability to convene experts prac-
19 ticed in the needs of a chronically ill patient, includ-
20 ing pharmacologists, psychiatrists, cardiologists,
21 pulmonologists, rheumatologists, nutritionists and
22 dieticians, social workers, and physical therapists.

23 (6) Partner with the Secretary of Health and
24 Human Services and the Secretary of Veterans Af-
25 fairs (including the Center for Health Services Re-

1 search in Primary Care of the Department of Vet-
2 erans Affairs Health Services Research and Develop-
3 ment Service), the medical community, medical
4 schools, and public health departments through the
5 Agency for Healthcare Research and Quality, the
6 Health Resources and Services Administration, and
7 the Association of American Medical Colleges to rou-
8 tinely develop new, forward thinking, and evidence-
9 based curricula that addresses the tremendous need
10 for team-based care and chronic care management.
11 Such curricula shall include palliative medicine,
12 chronic care management, leadership and team-
13 based skills and planning, and leveraging technology
14 as a care tool.

15 (c) OVERSIGHT AND EVALUATION.—

16 (1) IN GENERAL.—The Agency for Healthcare
17 Research and Quality shall be responsible for over-
18 sight and evaluation of all Chronic Care Innovation
19 Centers under this section.

20 (2) REPORTS.—Not less frequently than every
21 3 years, the Agency for Healthcare Research and
22 Quality shall submit to the Secretary of Health and
23 Human Services and to Congress a report con-
24 taining the findings of oversight and evaluations
25 conducted under paragraph (1).

(d) CONTRACT AUTHORITY.—In order to carry out this section, the Secretary may contract with existing Centers of Innovation (COINs) of the Department of Veterans Affairs Health Services Research and Development Service that meet the requirements described in subsection (c).

(e) AUTHORIZATION.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 7. CURRICULA REQUIREMENTS FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

"(9) NEW CURRICULA REQUIREMENTS.—

"(A) DEVELOPMENT.—The Secretary shall engage with the medical community and medical schools in developing curricula that meets the following requirements:

"(i) The curricula is new, forward thinking, and evidence-based.

"(ii) The curricula addresses the need for team-based care and chronic care management.

1 "(iii) The curricula includes palliative
2 medicine, chronic care management, lead-
3 ership and team-based skills and planning,
4 and leveraging technology as a care tool.
5 "(B) RURAL AREAS.—The curricula devel-
6 oped under subparagraph (A) shall include ap-
7 propriate focus on care practices required for
8 rural and underserved areas.
9 "(C) LIMITATION.—Notwithstanding the
10 preceding provisions of this subsection, for cost
11 reporting periods beginning on or after the date
12 that is 5 years after the date of enactment of
13 the Better Care, Lower Cost Act, if a hospital
14 has not begun to implement curricula that
15 meets the requirements described in subpara-
16 graph (A), payments otherwise made to a hos-
17 pital under this subsection may be reduced by
18 a percentage determined appropriate by the
19 Secretary. For purposes of the preceding sen-
20 tence, successful development and implementa-
21 tion of such curricula shall be determined by
22 program accrediting bodies.".
23 (b) INDIRECT GRADUATE MEDICAL EDUCATION PAY-
24 MENTS.—Section 1886(d)(5)(B) of the Social Security Act
25 (42 U.S.C. 1395ww(d)(5)(B)) is amended—

1 (1) by redesignating clause (x), as added by
2 section 5505(b) of the Patient Protection and Af-
3 fordable Care Act (Public Law 111–148), as clause
4 (xi) and moving such clause 6 ems to the left; and
5 (2) by adding at the end the following new
6 clause:
7 "(xii) Notwithstanding the preceding provisions of
8 this subparagraph, effective for discharges occurring on
9 or after the date that is 5 years after the date of enact-
10 ment of the Better Care, Lower Cost Act, if a hospital
11 has not begun to implement curricula that meets the re-
12 quirements described in subsection (h)(9)(A), as deter-
13 mined in accordance with subsection (h)(9)(C), payments
14 otherwise made to a hospital under this subparagraph may
15 be reduced by a percentage determined appropriate by the
16 Secretary.".

○