

114TH CONGRESS
2D SESSION

H. R. 6101

To amend title XVIII of the Social Security Act to improve the Medicare accountable care organization (ACO) program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 21, 2016

Mrs. BLACK (for herself and Mr. WELCH) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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

A BILL

To amend title XVIII of the Social Security Act to improve the Medicare accountable care organization (ACO) program, 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.**

4 This Act may be cited as the “ACO Improvement Act
5 of 2016”.

6 **SEC. 2. MEDICARE ACO PROGRAM IMPROVEMENTS.**

7 (a) IMPROVING OUTCOMES THROUGH GREATER
8 BENEFICIARY ENGAGEMENT.—

1 (1) IN GENERAL.—Section 1899 of the Social
2 Security Act (42 U.S.C. 1395jjj) is amended by add-
3 ing at the end the following new subsection:

4 “(1) IMPROVING OUTCOMES THROUGH GREATER
5 BENEFICIARY ENGAGEMENT.—

6 “(1) USE OF BENEFICIARY INCENTIVES.—Sub-
7 ject to approval of the Secretary, the Secretary shall
8 permit an ACO—

9 “(A) to reduce or eliminate cost-sharing
10 otherwise applicable under part B for some or
11 all primary care services (as identified by the
12 ACO) furnished by health care professionals
13 (including, as applicable, professionals fur-
14 nishing services through a rural health clinic or
15 Federally qualified health center) within the
16 network of the ACO; and

17 “(B) to develop additional incentives to en-
18 courage patient engagement and participation
19 in their own wellness.

20 The cost of the incentives under this paragraph shall
21 be borne by the ACO and shall not affect the pay-
22 ments to the ACO under subsection (d).

23 “(2) FOSTERING STRONGER PATIENT-PROVIDER
24 TIES.—

1 “(A) PERMITTING PROSPECTIVE ASSIGN-
2 MENT OF BENEFICIARIES.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), in carrying out subsection (c) with re-
5 spect to any agreement with an ACO
6 under this section, the ACO may elect
7 under any such agreement prospective as-
8 signment of Medicare fee-for-service bene-
9 ficiaries before the beginning of a year to
10 the ACO and a primary care ACO profes-
11 sional.

12 “(ii) BENEFICIARY SELECTION OF
13 PRIMARY CARE ACO PROFESSIONALS.—The
14 Secretary shall permit a beneficiary to se-
15 lect the primary care ACO professional
16 within the ACO to which the beneficiary is
17 assigned.

18 “(B) INCLUSION OF ACO INFORMATION IN
19 WELCOME TO MEDICARE VISIT AND ANNUAL
20 WELLNESS VISITS.—The Secretary may encour-
21 age a primary care ACO professional to include,
22 as part of the initial preventive physical exam-
23 ination under section 1861(ww)(1) or personal-
24 ized prevention plan services under section
25 1861(hhh)(1) for a Medicare fee-for-service

beneficiary assigned to that professional under this section, to provide the beneficiary with information concerning the ACO program under this section, including information on any cost-sharing reductions allowed under this section.

“(3) MOVING FROM VOLUME TO VALUE.—Subject to paragraph (4)—

“(A) REGULATORY RELIEF FOR MOVING TO TWO-SIDED RISK.—In the case of an ACO that has elected a two-sided risk model (as provided for under regulations), in addition to the authority provided under paragraph (1), the Secretary shall provide the following regulatory relief:

“(i) 3-DAY PRIOR HOSPITALIZATION WAIVER FOR SNF SERVICES.—Waiver of the 3-day prior hospitalization requirement for coverage of skilled nursing facility services.

“(ii) HOMEBOUND REQUIREMENT WAIVER FOR HOME HEALTH SERVICES.—Waiver of the homebound requirement for coverage of home health services.

“(B) IMPROVING CARE COORDINATION THROUGH ACCESS TO TELEHEALTH.—

1 “(i) FLEXIBILITY IN FURNISHING
2 TELEHEALTH SERVICES.—In applying sec-
3 tion 1834(m) in the case of an ACO, the
4 Secretary shall grant a waiver, and the
5 ACO may elect, to have the limitations on
6 originating site (under paragraph (4)(C) of
7 such section) and on the use of store-and-
8 forward technologies (under paragraph (1)
9 of such section) not apply. The previous
10 sentence shall not be construed as affect-
11 ing the authority of the Secretary under
12 subsection (f) to waive other provisions of
13 such section.

14 “(ii) PROVISION OF REMOTE MONI-
15 TORING IN CONNECTION WITH HOME
16 HEALTH SERVICES.—Nothing in this sec-
17 tion shall be construed as preventing an
18 ACO from paying for remote patient moni-
19 toring and home-based video conferencing
20 services in connection with the provision of
21 home health services (under conditions for
22 which payment for such services would not
23 be made under section 1895 for such serv-
24 ices) in a manner that is financially not

1 more expensive than the furnishing of a
2 home health visit.

3 “(C) MOVING UP RISK TRACK ANNU-
4 ALLY.—Each year of an agreement period, the
5 Secretary shall permit an ACO to make an elec-
6 tion to assume greater risk.

7 “(4) DISCRETIONARY REVOCATION.—The Sec-
8 retary may revoke, at the Secretary’s discretion, a
9 waiver granted under paragraph (3).

10 “(5) PROVISIONS FOR SHARING OF INTERNAL
11 COST SAVINGS.—

12 “(A) IN GENERAL.—Subject to the suc-
13 ceeding provisions of this paragraph, the Sec-
14 retary shall permit an ACO to distribute inter-
15 nal cost savings among ACO participants pur-
16 suant to an internal cost savings sharing ar-
17 rangement if the arrangement meets the re-
18 quirements of subparagraph (B) and the ACO
19 meets the reporting requirements of subpara-
20 graph (C) with respect to such arrangement.

21 “(B) REQUIREMENTS RELATING TO DE-
22 SIGN OF ARRANGEMENT.—The requirements of
23 this subparagraph for an internal cost savings
24 sharing arrangement of an ACO are as follows:

1 “(i) NO REDUCTION IN MEDICALLY
2 NECESSARY CARE.—ACO participants may
3 not reduce or limit medically necessary
4 items and services furnished to Medicare
5 fee-for-service beneficiaries.

6 “(ii) VOLUNTARY PARTICIPATION.—
7 Participation by providers of services and
8 suppliers in the arrangement is voluntary.

9 “(iii) TRANSPARENCY.—The arrange-
10 ment is transparent and subject to audit
11 by the Secretary.

12 “(iv) QUALITY OF CARE.—ACO par-
13 ticipants participating in the arrangement
14 meet quality performance standards estab-
15 lished by the Secretary under subsection
16 (b)(3).

17 “(v) PAYMENT METHODOLOGY.—Dis-
18 tributions of internal cost savings under
19 the arrangement is not based on the vol-
20 ume or value of referrals or business other-
21 wise generated.

22 “(C) REPORTING REQUIREMENTS.—The
23 requirements of this subparagraph for an ar-
24 rangement of an ACO is that the ACO provides

the following information to the Secretary for purposes of evaluating the arrangement:

“(i) **METHODOLOGY.**—The methodology for distributions of internal cost savings under the arrangement among all ACO participants, including the frequency of and the criteria for such distributions.

“(ii) **CARE REDESIGN.**—A detailed explanation of how the arrangement will achieve improved quality and patient experience, as well as the anticipated cost savings.

“(iii) **ELIGIBILITY TO PARTICIPATE IN ARRANGEMENT.**—The criteria for participation by ACO participants, particularly professionals, in the arrangement.

“(iv) **DISTRIBUTION PLAN.**—A comprehensive plan for distributions of internal cost savings under the arrangement.

“(D) **WAIVERS.**—The Secretary shall waive such provisions of this title and title XI as may be necessary to carry out this paragraph.

“(E) **DEFINITIONS.**—In this paragraph:

“(i) **INTERNAL COST SAVINGS SHARING ARRANGEMENT.**—The term ‘internal

1 cost savings sharing arrangement’ means
2 an arrangement among ACO participants
3 of an ACO for the distributions of internal
4 cost savings to such ACO participants, in-
5 cluding to ACO professionals, solely from
6 gains or savings that are a direct result of
7 collaborative efforts among ACO partici-
8 pants of an ACO to improve the quality
9 and efficiency of care furnished to Medi-
10 care fee-for-service beneficiaries, but does
11 not include shared savings under sub-
12 section (d)(2).

13 “(ii) DISTRIBUTION OF INTERNAL
14 COST SAVINGS.—The term ‘distribution of
15 internal cost savings’ means a payment of
16 a percentage of the gains or savings from
17 an internal cost savings sharing arrange-
18 ment to ACO participants.

19 “(iii) ACO PARTICIPANTS.—The term
20 ‘ACO participants’ means providers of
21 services and suppliers participating in an
22 ACO who voluntarily participate in an in-
23 ternal cost savings sharing arrangement
24 under this paragraph.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply as if included in the
3 enactment of section 3022 of Public Law 111–148.

4 (3) CONFORMING AMENDMENT.—Effective as if
5 included in the enactment of section 3021 of Public
6 Law 111–148, the provisions of section 1899(l)(5) of
7 the Social Security Act (relating to authority for dis-
8 tributions of internal cost savings under internal
9 cost savings sharing arrangements), as added by
10 paragraph (1), shall apply to participants in ac-
11 countable care organization payment and service de-
12 livery models (and other appropriate models) tested
13 pursuant to section 1115A of the Social Security Act
14 (42 U.S.C. 1315a).

15 (b) STUDY AND REPORT ON FEASIBILITY ON PRO-
16 VIDING ELECTRONIC ACCESS TO MEDICARE CLAIMS
17 DATA.—

18 (1) STUDY.—The Secretary of Health and
19 Human Services shall conduct a study regarding the
20 feasibility of establishing a system of electronic ac-
21 cess of providers of services and suppliers to in-proc-
22 ess and complete patient claims data. Such system
23 may be a modification of an existing database, such
24 as the Virtual Research Data Center. The study
25 shall take into account the measures needed to en-

1 sure the security and privacy of beneficiary and pro-
2 vider information.

3 (2) REPORT.—Not later than six months after
4 the date of the enactment of this Act, the Secretary
5 shall submit to Congress a report on such study.
6 The Secretary shall include in such report such rec-
7 ommendations as the Secretary deems appropriate.

8 (c) ASSIGNMENT TAKING INTO ACCOUNT SERVICES
9 OF NON-PHYSICIAN PRACTITIONERS IN CASES OF ACOS
10 IN RURAL OR UNDERSERVED AREAS OR AFFILIATED
11 WITH AN FQHC OR RURAL HEALTH CLINIC.—Section
12 1899(c) of the Social Security Act (42 U.S.C. 1395jjj(c))
13 is amended by inserting before the period at the end the
14 following: “, except that, for performance years beginning
15 on or after January 1, 2017, in the case of an ACO that
16 is located in a rural or medically underserved area or that
17 is affiliated with a Federally qualified health center or
18 rural health clinic, such determination shall be based on
19 their utilization of primary care services provided under
20 this title by any ACO professional”.

21 (d) PERMITTING DE MINIMIS VARIATION FROM MIN-
22 IMUM ENROLLMENT REQUIREMENT.—Section
23 1899(b)(2)(D) of the Social Security Act (42 U.S.C.
24 1395jjj(b)(2)(D)) is amended by inserting before the pe-
25 riod at the end the following: “, except that the Secretary

1 may permit an ACO with fewer than 5,000 participants
2 by a de minimis number (not to exceed 100) to be eligible
3 to continue to participate in cases where such fewer num-
4 ber does not negatively impact the ACO’s participation in
5 the program and the ACO meets other conditions to be
6 so eligible”.

7 (e) PAYMENTS FOR SHARED SAVINGS.—Section
8 1899(d)(2) of the Social Security Act (42 U.S.C.
9 1395jjj(d)(2)) is amended by adding at the end the fol-
10 lowing: “For plan years beginning on or after January 1,
11 2017, the Secretary may use a sliding scale to increase
12 by up to 10 percentage points the appropriate percent oth-
13 erwise applied under this paragraph for an ACO that
14 achieves the median of quality performance standards, or
15 achieves quality improvement scores above such median,
16 established under subsection (b)(3). The Secretary shall
17 not decrease such appropriate percent otherwise applied
18 to an ACO because of the application of an increase under
19 the previous sentence for another ACO.”.

20 (f) DEMONSTRATION FOR ALLOWING GROWTH OF
21 HCC SCORES.—Section 1899(d)(1)(B)(ii) of the Social
22 Security Act (42 U.S.C. 1395jjj(d)(1)(B)(ii)) is amended
23 by adding at the end the following: “In carrying out this
24 subsection, the Secretary shall establish a 3-year dem-
25 onstration project that develops and applies a method-

1 ology, similar to the Medicare Advantage normalization
2 factor applied under section 1853(a)(3), that allows
3 growth of HCC scores for those who are continuously en-
4 rolled with an ACO. The Secretary shall submit to Con-
5 gress a report on the results of such demonstration
6 project.”.

7 (g) CREATING INCENTIVES FOR ACO DEVELOP-
8 MENT.—The Secretary of Health and Human Services
9 may develop a mechanism to make permanent those ACO-
10 related pilot programs, including the Advance Payment
11 ACO Model, that have been successful. The Secretary
12 shall submit to Congress a report on the mechanism and
13 shall include in the report such recommendations, includ-
14 ing such changes in legislation, as the Secretary deems
15 appropriate.

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