115TH CONGRESS
1ST SESSION

S. 870

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

IN THE SENATE OF THE UNITED STATES

APRIL 6 (legislative day, APRIL 4), 2017

Mr. HATCH (for himself, Mr. WYDEN, Mr. ISAKSON, Mr. WARNER, Mr. BENNET, Mr. CARDIN, Mr. THUNE, Mr. CASEY, Mr. CORNYN, Mr. CRAPO, Mr. GRASSLEY, Mr. CARPER, Ms. STABENOW, and Mrs. MCCASKILL) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017''.

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

TITLE I—RECEIVING HIGH QUALITY CARE IN THE HOME

SEC. 101. EXTENDING THE INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

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

(1) in subsection (e)—

(A) in paragraph (1), by striking ''5-year period'' and inserting ''7-year period''; and

(B) in paragraph (5), by striking ''10,000'' and inserting ''15,000''; and

(2) in subsection (i), by striking ''second of 2'' and inserting ''third of 3''.

SEC. 102. EXPANDING ACCESS TO HOME DIALYSIS THERAPY.

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

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

(2) in clause (ii), as redesignated by subparagraph (A), strike ''on a comprehensive'' and insert ''subject to subparagraph (B), on a comprehensive'';

(3) by striking ''With respect to'' and inserting ''(A) With respect to''; and

(4) by adding at the end the following new subparagraph:

''(B) For purposes of subparagraph (A)(ii), an individual determined to have end stage renal disease receiving home dialysis may choose to receive the monthly end stage renal disease-related visits furnished on or after January 1, 2019, via telehealth if the individual receives a face-to-face visit, without the use of telehealth, at least once every three consecutive months.''.

(b) ORIGINATING SITE REQUIREMENTS.—

(1) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

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

''(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).

''(X) The home of an individual, but only for purposes of section 1881(b)(3)(B).''; and

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

''(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic require-

ments described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).''.

(2) NO FACILITY FEE IF ORIGINATING SITE FOR HOME DIALYSIS THERAPY IS THE HOME.—Section 1834(m)(2)(B) of the Social Security (42 U.S.C. 1395m(m)(2)(B)) is amended—

(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), and indenting appropriately;

(B) in subclause (II), as redesignated by subparagraph (A), by striking ''clause (i) or this clause'' and inserting ''subclause (I) or this subclause'';

(C) by striking ''SITE.—With respect to'' and inserting ''SITE.—

''(i) IN GENERAL.—Subject to clause (ii), with respect to''; and

(D) by adding at the end the following new clause:

''(ii) NO FACILITY FEE IF ORIGINATING SITE FOR HOME DIALYSIS THER-

APY IS THE HOME.—No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).''.

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

TITLE II—ADVANCING TEAM-BASED CARE

SEC. 201. PROVIDING CONTINUED ACCESS TO MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR VULNERABLE POPULATIONS.

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

(b) INCREASED INTEGRATION OF DUAL SNPS.—

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

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

''(F) The plan meets the requirements applicable under paragraph (8).''; and

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

"(8) INCREASED INTEGRATION OF DUAL SNPS.—

"(A) DESIGNATED CONTACT.—The Secretary, acting through the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act, shall serve as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this paragraph and, consistent with such role, shall—

"(i) establish a uniform process for disseminating to State Medicaid agencies information under this title impacting contracts between such agencies and such plans under this subsection; and

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

"(B) UNIFIED GRIEVANCES AND APPEALS PROCESS.—

''(i) IN GENERAL.—Not later than April 1, 2020, the Secretary shall establish procedures, to the extent feasible, unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and 1932(b)(4) for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX. The Secretary shall solicit comment in developing such procedures from States, plans, beneficiaries and their representatives, and other relevant stakeholders.

''(ii) PROCEDURES.—The procedures established under clause (i) shall be included in the plan contract under paragraph (3)(D) and shall—

''(I) adopt the provisions for the enrollee that are most protective for the enrollee and, to the extent feasible as determined by the Secretary, are compatible with unified timeframes and consolidated access to external review under an integrated process;

''(II) take into account differences in State plans under title XIX to the extent necessary;

''(III) be easily navigable by an enrollee; and

''(IV) include the elements described in clause (iii), as applicable.

''(iii) ELEMENTS DESCRIBED.—Both unified appeals and unified grievance procedures shall include, as applicable, the following elements described in this clause:

''(I) Single written notification of all applicable grievances and appeal rights under this title and title XIX. For purposes of this subparagraph, the Secretary may waive the requirements under section 1852(g)(1)(B) when the specialized MA plan covers items or services under this part or under title XIX.

''(II) Single pathways for resolution of any grievance or appeal related to a particular item or service provided by specialized MA plans for special needs individuals described in

subsection (b)(6)(B)(ii) under this title and title XIX.

''(III) Notices written in plain language and available in a language and format that is accessible to the enrollee, including in non-English languages that are prevalent in the service area of the specialized MA plan.

''(IV) Unified timeframes for grievances and appeals processes, such as an individual's filing of a grievance or appeal, a plan's acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

''(V) Requirements for how the plan must process, track, and resolve grievances and appeals, to ensure beneficiaries are notified on a timely basis of decisions that are made throughout the grievance or appeals process and are able to easily determine the status of a grievance or appeal.

"(iv) CONTINUATION OF BENEFITS PENDING APPEAL.—The unified procedures under clause (i) shall, with respect to all benefits under parts A and B and title XIX subject to appeal under such procedures, incorporate provisions under current law and implementing regulations that provide continuation of benefits pending appeal under this title and title XIX.

"(C) REQUIREMENT FOR UNIFIED GRIEVANCES AND APPEALS.—For 2021 and subsequent years, the contract of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under paragraph (3)(D) shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

"(D) REQUIREMENTS FOR INTEGRATION.—For 2022 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall meet one or more of the following requirements, to the extent permitted under State law, for integration of benefits under this title and title XIX:

"(i) The specialized MA plan must meet the requirements of contracting with the State Medicaid agency described in paragraph (3)(D) in addition to coordinating long-term services and supports or behavioral health services, or both, by meeting an additional minimum set of requirements determined by the Secretary through the Federal Coordinated Health Care Office established under section 2018 of the Patient Protection and Affordable Care Act based on input from stakeholders, such as notifying the State in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees, assigning one primary care provider for each enrollee, or sharing data that would benefit the coordination of items and services under this title and the State plan under title XIX. Such minimum set of requirements must be included in the contract of the specialized MA plan with the State Medicaid agency under such paragraph.

''(ii) The specialized MA plan must meet the requirements of a fully integrated plan described in section 1853(a)(1)(B)(iv)(II) (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the PACE program), or enter into a capitated contract with the State Medicaid agency to provide long-term services and supports or behavioral health services, or both.

''(iii) In the case where an individual is enrolled in the specialized MA plan and a Medicaid managed care organization (as defined in section 1903(m)(1)(A)) that provides long term services and supports or behavioral health services with the same parent organization, the parent organization offering both the specialized MA plan and the Medicaid managed care plan must assume clinical and financial responsibility for benefits provided under this title and title XIX.''.

(2) CONFORMING AMENDMENT TO RESPONSIBILITIES OF FEDERAL COORDINATED HEALTH

CARE OFFICE.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)) is amended by adding at the end the following new paragraphs:

''(6) To act as a designated contact for States under subsection (f)(8)(A) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section.

''(7) To be responsible for developing regulations and guidance related to the implementation of a unified grievance and appeals process as described in subparagraphs (B) and (C) of section 1859(f)(8) of the Social Security Act (42 U.S.C. 1395w–28(f)(8)).''.

(c) IMPROVEMENTS TO SEVERE OR DISABLING CHRONIC CONDITION SNPS.—

(1) CARE MANAGEMENT REQUIREMENTS.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended—

(A) by striking ''ALL SNPS.—The requirements'' and inserting ''ALL SNPS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the requirements'';

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

(C) in clause (ii), as redesignated by subparagraph (B), by redesignating clauses (i) through (iii) as subclauses (I) through (III), respectively, and indenting appropriately; and

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

''(B) IMPROVEMENTS TO CARE MANAGEMENT REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—For 2020 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the requirements described in this paragraph include the following:

''(i) The interdisciplinary team under subparagraph (A)(ii)(III) includes a team of providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the plan.

''(ii) Requirements developed by the Secretary to provide face-to-face encoun-

ters with individuals enrolled in the plan not less frequently than on an annual basis.

''(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individual's individualized care plan under clause (ii)(II) of such subparagraph.

''(iv) As part of the annual evaluation and approval of such model of care, the Secretary shall take into account whether the plan fulfilled the previous year's goals (as required under the model of care).

''(v) The Secretary shall establish a minimum benchmark for each element of the model of care of a plan. The Secretary shall only approve a plan's model of care under this paragraph if each element of the model of care meets the minimum benchmark applicable under the preceding sentence.''.

(2) REVISIONS TO THE DEFINITION OF A SEVERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED NEEDS INDIVIDUAL.—

(A) IN GENERAL.—Section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amended—

(i) by striking ''who have'' and inserting ''who—

''(I) before January 1, 2022, have'';

(ii) in subclause (I), as added by clause (i), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(II) on or after January 1, 2022, have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under subsection (f)(9)(A).''.

(B) PANEL OF CLINICAL ADVISORS.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

''(9) LIST OF CONDITIONS FOR CLARIFICATION OF THE DEFINITION OF A SEVERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED NEEDS INDIVIDUAL.—

''(A) IN GENERAL.—Not later than December 31, 2020, and every 5 years thereafter, the Secretary shall convene a panel of clinical advisors to establish and update a list of conditions that meet each of the following criteria:

''(i) Conditions that meet the definition of a severe or disabling chronic condition under subsection (b)(6)(B)(iii) on or after January 1, 2022.

''(ii) Conditions that—

''(I) require prescription drugs, providers, and models of care that are unique to the specific population of enrollees in a specialized MA plan for special needs individuals described in such subsection on or after such date

and would not be needed by the general population of beneficiaries under this title; and

''(II) have a low prevalence in the general population of beneficiaries under this title or a disproportionally high per-beneficiary cost under this title.

''(B) REQUIREMENT.—In establishing and updating the list under subparagraph (A), the panel shall take into account the availability of varied benefits, cost-sharing, and supplemental benefits under the model described in paragraph (2) of section 1859(h), including the expansion under paragraph (1) of such section.''.

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

''(6) QUALITY MEASUREMENT AT THE PLAN LEVEL FOR SNPS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may require reporting

of data under section 1852(e) for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

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

''(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

''(ii) if quality measures are reported at the plan level, ensure that MA plans are not required to provide duplicative information; and

''(iii) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

"(C) APPLICATION.—If the Secretary applies quality measurement at the plan level under this paragraph, such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D.

"(7) DETERMINATION OF FEASIBILITY OF QUALITY MEASUREMENT AT THE PLAN LEVEL FOR ALL MA PLANS.—

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

"(B) CONSIDERATION OF CHANGE.—After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph.".

(e) GAO STUDY AND REPORT ON STATE-LEVEL INTEGRATION BETWEEN DUAL SNPS AND MEDICAID.—

(1) STUDY.—The Comptroller General of the United States (in this paragraph referred to as the ''Comptroller General'') shall conduct a study on State-level integration between specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.). Such study shall include an analysis of the following:

(A) The characteristics of States in which the State agency responsible for administering the State plan under such title XIX has a contract with such a specialized MA plan and that delivers long term services and supports under the State plan under such title XIX through a managed care program, including the requirements under such State plan with respect to long term services and supports.

(B) The types of such specialized MA plans, which may include the following:

(i) A plan described in section 1853(a)(1)(B)(iv)(II) of such Act (42 U.S.C. 1395w–23(a)(1)(B)(iv)(II)).

(ii) A plan that meets the requirements described in subsection (f)(3)(D) of such section 1859.

(iii) A plan described in clause (ii) that also meets additional requirements established by the State.

(C) The characteristics of individuals enrolled in such specialized MA plans.

(D) As practicable, the following with respect to State programs for the delivery of long term services and supports under such title XIX through a managed care program:

(i) Which populations of individuals are eligible to receive such services and supports.

(ii) Whether all such services and supports are provided on a capitated basis or if any of such services and supports are carved out and provided through fee-for-service.

(E) How the availability and variation of integration arrangements of such specialized

MA plans offered in States affects spending, service delivery options, access to community-based care, and utilization of care.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

TITLE III—EXPANDING INNOVATION AND TECHNOLOGY

SEC. 301. ADAPTING BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL MEDICARE ADVANTAGE ENROLLEES.

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

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

''(1) IN GENERAL.—In implementing the model described in paragraph (2) proposed to be tested under section 1115A(b), the Secretary shall revise the testing of the model under such section to cover, effective not later than January 1, 2020, all States.

''(2) MODEL DESCRIBED.—The model described in this paragraph is the testing of a model of Medicare Advantage value-based insurance design that would allow Medicare Advantage plans the option to propose and design benefit structures that vary benefits, cost-sharing, and supplemental benefits offered to enrollees with specific chronic diseases proposed to be carried out in Oregon, Arizona, Texas, Iowa, Michigan, Indiana, Tennessee, Alabama, Pennsylvania, and Massachusetts.

''(3) TERMINATION AND MODIFICATION PROVISION NOT APPLICABLE UNTIL JANUARY 1, 2022.—The provisions of section 1115A(b)(3)(B) shall apply to the model described in paragraph (2), including such model as expanded under paragraph (1), beginning January 1, 2022, but shall not apply to such model, as so expanded, prior to such date.

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

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

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

(1) in subparagraph (A), by striking ''Each'' and inserting ''Subject to subparagraph (D), each''; and

(2) by adding at the end the following new subparagraph:

''(D) EXPANDING SUPPLEMENTAL BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL ENROLLEES.—

''(i) IN GENERAL.—For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

''(ii) SUPPLEMENTAL BENEFITS DESCRIBED.—

''(I) IN GENERAL.—Supplemental benefits described in this clause are supplemental benefits that, with re-

spect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

''(II) AUTHORITY TO WAIVE UNIFORMITY REQUIREMENTS.—The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirement under subsection (d)(1)(A), as determined appropriate by the Secretary.

''(iii) CHRONICALLY ILL ENROLLEE DEFINED.—In this subparagraph, the term 'chronically ill enrollee' means an enrollee in an MA plan that the Secretary determines—

''(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

''(II) has a high risk of hospitalization or other adverse health outcomes; and

''(III) requires intensive care coordination.''.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study on supplemental benefits provided to enrollees in Medicare Advantage plans under part C of title XVIII of the Social Security Act. Such study shall include an analysis of the following:

(A) The type of supplemental benefits provided to such enrollees, the total number of enrollees receiving each supplemental benefit, and whether the supplemental benefit is covered by the standard benchmark cost of the benefit or with an additional premium.

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

(C) The impact supplemental benefits have on—

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

(ii) the utilization of items and services for which benefits are available under the original Medicare fee-for-service program option under parts A and B of such title XVIII by such enrollees; and

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

(2) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 303. INCREASING CONVENIENCE FOR MEDICARE ADVANTAGE ENROLLEES THROUGH TELEHEALTH.

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

(1) in subsection (a)(1)(B)(i), by inserting ", subject to subsection (m)," after "means"; and

(2) by adding at the end the following new subsection:

"(m) PROVISION OF ADDITIONAL TELEHEALTH BENEFITS.—

"(1) MA PLAN OPTION.—For plan year 2020 and subsequent plan years, subject to the requirements of paragraph (3), an MA plan may provide additional telehealth benefits (as defined in paragraph (2)) to individuals enrolled under this part.

"(2) ADDITIONAL TELEHEALTH BENEFITS DEFINED.—

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

"(i) DEFINITION.—The term 'additional telehealth benefits' means services—

"(I) for which benefits are available under part B, including services for which payment is not made under section 1834(m) due to the conditions for payment under such section; and

"(II) that are identified as clinically appropriate to furnish using electronic information and telecommuni-

cations technology when a physician (as defined in section 1861(r)) or practitioner (described in section 1842(b)(18)(C)) providing the service is not at the same location as the plan enrollee.

''(ii) EXCLUSION OF CAPITAL AND INFRASTRUCTURE COSTS AND INVESTMENTS.—The term 'additional telehealth benefits' does not include capital and infrastructure costs and investments relating to such benefits.

''(B) PUBLIC COMMENT.—Not later than November 30, 2018, the Secretary shall solicit comments on what types of telehealth services currently offered to enrollees under this part through supplemental health care benefits should be considered to meet the definition of additional telehealth benefits under this paragraph.

''(3) REQUIREMENTS FOR ADDITIONAL TELEHEALTH BENEFITS.—The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

''(A) Physician or practitioner licensure and other requirements such as specific training.

''(B) Factors necessary to ensure the coordination of such benefits with items and services furnished in-person.

''(C) Such other areas as determined by the Secretary.

''(4) ENROLLEE CHOICE.—If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2)), an individual enrollee shall have discretion as to whether to receive such service as an additional telehealth benefit.

''(5) CONSTRUCTION REGARDING NETWORK ACCESS ADEQUACY.—Provision of additional telehealth benefits under this subsection shall not be construed as making such benefits available and accessible for purposes of compliance with subsection (d).

''(6) TREATMENT UNDER MA.—For purposes of this subsection and section 1854, additional telehealth benefits shall be treated as if they were benefits under the original Medicare fee-for-service program option.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the require-

ment under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1834(m).''.

(b) CLARIFICATION REGARDING INCLUSION IN BID AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)(ii)(I)) is amended by inserting '', including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1852(m)'' before the semicolon at the end.

SEC. 304. PROVIDING ACCOUNTABLE CARE ORGANIZATIONS THE ABILITY TO EXPAND THE USE OF TELEHEALTH.

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

''(l) PROVIDING ACOS THE ABILITY TO EXPAND THE USE OF TELEHEALTH SERVICES.—

''(1) IN GENERAL.—In the case of telehealth services for which payment would otherwise be made under this title furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services fur-

nished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

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

"(B) NO APPLICATION OF GEOGRAPHIC LIMITATION.—The geographic limitation under section 1834(m)(4)(C)(i) shall not apply with respect to an originating site described in section 1834(m)(4)(C)(ii) (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

"(2) DEFINITIONS.—In this subsection:

"(A) APPLICABLE ACO.—The term 'applicable ACO' means an ACO participating in a model tested or expanded under section 1115A or under this section—

"(i) that operates under a two-sided model—

"(I) described in section 425.600(a) of title 42, Code of Federal Regulations; or

"(II) tested or expanded under section 1115A; and

"(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using a prospective assignment method, as determined appropriate by the Secretary.

"(B) HOME.—The term 'home' means, with respect to a Medicare fee-for-service beneficiary, the place of residence used as the home of the beneficiary.

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

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

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

(b) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study on the implementation of section 1899(l) of the Social Security Act, as added by subsection (a). Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

(B) COLLECTION OF DATA.—The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

(2) REPORT.—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 305. EXPANDING THE USE OF TELEHEALTH FOR INDIVIDUALS WITH STROKE.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by section 102(b)(2), is amended by adding at the end the following new paragraph:

''(6) TREATMENT OF STROKE TELEHEALTH SERVICES.—

''(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of evaluation of an acute stroke, as determined by the Secretary.

''(B) NO ORIGINATING SITE FACILITY FEE.—The Secretary shall not pay an originating site facility fee (as described in paragraph (2)(B)) with respect to such telehealth services.''.

TITLE IV—IDENTIFYING THE CHRONICALLY ILL POPULATION

SEC. 401. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACCOUNTABLE CARE ORGANIZATION.

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

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(2) by striking ''ACOs.—The Secretary'' and inserting ''ACOs.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary''; and

(3) by adding at the end the following new paragraph:

''(2) PROVIDING FLEXIBILITY.—

''(A) CHOICE OF PROSPECTIVE ASSIGNMENT.—For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

''(B) ASSIGNMENT BASED ON VOLUNTARY IDENTIFICATION BY MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

''(i) IN GENERAL.—For performance year 2019 and each subsequent performance year, if a system is available for elec-

tronic designation, the Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

''(ii) NOTIFICATION PROCESS.—The Secretary shall establish a process under which a Medicare fee-for-service beneficiary is—

''(I) notified of their ability to make an identification described in clause (i); and

''(II) informed of the process by which they may make and change such identification.

''(iii) SUPERSEDING CLAIMS-BASED ASSIGNMENT.—A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede any claims-based assignment otherwise determined by the Secretary.''.

TITLE V—EMPOWERING INDIVIDUALS AND CAREGIVERS IN CARE DELIVERY

SEC. 501. ELIMINATING BARRIERS TO CARE COORDINATION UNDER ACCOUNTABLE CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1899 of the Social Security Act (42 U.S.C. 1395jjj), as amended by section 304(a), is amended—

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

''(I) An ACO that seeks to operate an ACO Beneficiary Incentive Program pursuant to subsection (m) shall apply to the Secretary at such time, in such manner, and with such information as the Secretary may require.'';

(2) by adding at the end the following new subsection:

''(m) AUTHORITY TO PROVIDE INCENTIVE PAYMENTS TO BENEFICIARIES WITH RESPECT TO QUALIFYING PRIMARY CARE SERVICES.—

''(1) PROGRAM.—

''(A) IN GENERAL.—In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an

ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary's discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

''(B) IMPLEMENTATION.—The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date shall be no earlier than January 1, 2019, and no later than January 1, 2020.

''(2) CONDUCT OF PROGRAM.—

''(A) DURATION.—Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be conducted for such period (of not less than 1 year) as the Secretary may approve.

''(B) SCOPE.—An ACO Beneficiary Incentive Program established under this subsection

shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who are furnished qualifying services by the ACO:

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

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

''(C) QUALIFYING SERVICE.—For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20 of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

"(i) an ACO professional described in subsection (h)(1)(A) who has a primary care specialty designation included in the definition of primary care physician under section 425.20 of title 42, Code of Federal Regulations (or any successor regulation);

"(ii) an ACO professional described in subsection (h)(1)(B); or

"(iii) a Federally qualified health center or rural health clinic (as such terms are defined in section 1861(aa)).

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

"(i) in an amount up to $20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

"(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph

(B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1882(g)(1)), in a State Medicaid plan under title XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

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

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

''(E) NO SEPARATE PAYMENTS FROM THE SECRETARY.—The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received

under this section to carry out an ACO Beneficiary Incentive Program.

"(F) NO APPLICATION TO SHARED SAVINGS CALCULATION.—Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

"(G) REPORTING REQUIREMENTS.—An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Secretary may require, including the amount and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

"(H) TERMINATION.—The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any time for reasons determined appropriate by the Secretary.

''(3) EXCLUSION OF INCENTIVE PAYMENTS.—Any payment made under an ACO Beneficiary Incentive Program established under this subsection shall not be considered income or resources or otherwise taken into account for purposes of—

''(A) determining eligibility for benefits or assistance (or the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds; or

''(B) any Federal or State laws relating to taxation.'';

(3) in subsection (e), by inserting '', including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''the program''; and

(4) in subsection (g)(6), by inserting ''or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''under subsection (d)(4)''.

(b) AMENDMENT TO SECTION 1128B.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

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

(c) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an evaluation of the ACO Beneficiary Incentive Program established under subsections (b)(2)(I) and (m) of section 1899 of the Social Security Act (42 U.S.C. 1395jjj), as added by subsection (a). The evaluation shall include an analysis of the impact of the implementation of the Program on expenditures and beneficiary health outcomes under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) REPORT.—Not later than October 1, 2023, the Secretary shall submit to Congress a report containing the results of the evaluation under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

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

(a) STUDY.—The Comptroller General shall conduct a study on the establishment under part B of the Medicare program under title XVIII of the Social Security Act of a payment code for a visit for longitudinal comprehensive care planning services. Such study shall include an analysis of the following to the extent such information is available:

(1) The frequency with which services similar to longitudinal comprehensive care planning services are furnished to Medicare beneficiaries, which providers of services and suppliers are furnishing those services, whether Medicare reimbursement is being received for those services, and, if so, through which codes those services are being reimbursed.

(2) Whether, and the extent to which, longitudinal comprehensive care planning services would

overlap, and could therefore result in duplicative payment, with services covered under the hospice benefit as well as the chronic care management code, evaluation and management codes, or other codes that already exist under part B of the Medicare program.

(3) Any barriers to hospitals, skilled nursing facilities, hospice programs, home health agencies, and other applicable providers working with a Medicare beneficiary to engage in the care planning process and complete the necessary documentation to support the treatment and care plan of the beneficiary and provide such documentation to other providers and the beneficiary or his representative.

(4) Any barriers to providers, other than the provider furnishing longitudinal comprehensive care planning services, accessing the care plan and associated documentation for use related to the care of the Medicare beneficiary.

(5) Potential options for ensuring that applicable providers are notified of a patient's existing longitudinal care plan and that applicable providers consider that plan in making their treatment decisions, and what the challenges might be in implementing such options.

(6) Stakeholder's views on the need for the development of quality metrics with respect to longitudinal comprehensive care planning services, such as measures related to—

(A) the process of eliciting input from the Medicare beneficiary or from a legally authorized representative and documenting in the medical record the patient-directed care plan;

(B) the effectiveness and patient-centeredness of the care plan in organizing delivery of services consistent with the plan;

(C) the availability of the care plan and associated documentation to other providers that care for the beneficiary; and

(D) the extent to which the beneficiary received services and support that is free from discrimination based on advanced age, disability status, or advanced illness.

(7) Stakeholder's views on how such quality metrics would provide information on—

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

(B) the documentation of the care plan;

(C) services furnished to the beneficiary; and

(D) outcomes of treatment.

(8) Stakeholder's views on—

(A) the type of training and education needed for applicable providers, individuals, and caregivers in order to facilitate longitudinal comprehensive care planning services;

(B) the types of providers of services and suppliers that should be included in the interdisciplinary team of an applicable provider; and

(C) the characteristics of Medicare beneficiaries that would be most appropriate to receive longitudinal comprehensive care planning services, such as individuals with advanced disease and individuals who need assistance with multiple activities of daily living.

(9) Stakeholder's views on the frequency with which longitudinal comprehensive care planning services should be furnished.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) DEFINITIONS.—In this section:

(1) APPLICABLE PROVIDER.—The term ''applicable provider'' means a hospice program (as defined in subsection (dd)(2) of section 1861 of the Social Security Act (42 U.S.C. 1395ww)) or other provider of services (as defined in subsection (u) of such section) or supplier (as defined in subsection (d) of such section) that—

(A) furnishes longitudinal comprehensive care planning services through an interdisciplinary team; and

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

(2) COMPTROLLER GENERAL.—The term ''Comptroller General'' means the Comptroller General of the United States.

(3) INTERDISCIPLINARY TEAM.—The term ''interdisciplinary team'' means a group that—

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

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

(C) may include other direct care personnel.

(4) LONGITUDINAL COMPREHENSIVE CARE PLANNING SERVICES.—The term ''longitudinal com-

prehensive care planning services'' means a voluntary shared decisionmaking process that is furnished by an applicable provider through an interdisciplinary team and includes a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness. The purpose of such services is to discuss a longitudinal care plan that addresses the progression of the disease, treatment options, the goals, values, and preferences of the beneficiary, and the availability of other resources and social supports that may reduce the beneficiary's health risks and promote self-management and shared decisionmaking.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

SEC. 601. GAO STUDY AND REPORT ON IMPROVING MEDICATION SYNCHRONIZATION.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the extent to which Medicare prescription drug plans (MA–PD plans and standalone prescription drug plans) under part D of title

XVIII of the Social Security Act and private payors use programs that synchronize pharmacy dispensing so that individuals may receive multiple prescriptions on the same day to facilitate comprehensive counseling and promote medication adherence. The study shall include a review of the following:

(1) The extent to which pharmacies have adopted such programs.

(2) The common characteristics of such programs, including how pharmacies structure counseling sessions under such programs and the types of payment and other arrangements that Medicare prescription drug plans and private payors employ under such programs to support the efforts of pharmacies.

(3) How such programs compare for Medicare prescription drug plans and private payors.

(4) What is known about how such programs affect patient medication adherence and overall patient health outcomes and health outcomes, including if adherence and outcomes vary by patient subpopulations, such as disease state and socioeconomic status.

(5) What is known about overall patient satisfaction with such programs and satisfaction with

such programs, including within patient subpopulations, such as disease state and socioeconomic status.

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

(7) Barriers to the use of medication synchronization programs by Medicare prescription drug plans.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the use of prescription drugs to manage the weight of obese patients and the impact of coverage of such drugs on patient health and on health care spending. Such study shall examine the use and impact of these obesity drugs in the non-Medicare population and for Medicare beneficiaries who have such drugs covered through an MA–PD plan (as defined in sec-

tion 1860D–1(a)(3)(C) of the Social Security Act (42 U.S.C. 1395w–101(a)(3)(C))) as a supplemental health care benefit. The study shall include an analysis of the following:

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

(2) The utilization of obesity drugs.

(3) The distribution of Body Mass Index by individuals taking obesity drugs, to the extent practicable.

(4) What is known about the use of obesity drugs in conjunction with the receipt of other items or services, such as behavioral counseling, and how these compare to items and services received by obese individuals who do not take obesity drugs.

(5) Physician considerations and attitudes related to prescribing obesity drugs.

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

(7) What is known about the extent to which individuals who take obesity drugs adhere to the prescribed regimen.

(8) What is known about the extent to which individuals who take obesity drugs maintain weight loss over time.

(9) What is known about the subsequent impact such drugs have on medical services that are directly related to obesity, including with respect to subpopulations determined based on the extent of obesity.

(10) What is known about the spending associated with the care of individuals who take obesity drugs, compared to the spending associated with the care of individuals who do not take such drugs.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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