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SEPTEMBER 27, 2017

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

AN ACT

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

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—RECEIVING HIGH QUALITY CARE IN THE HOME

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

Sec. 102. Expanding access to home dialysis therapy.

TITLE II—ADVANCING TEAM-BASED CARE

Sec. 201. Providing continued access to Medicare Advantage special needs plans for vulnerable populations.

TITLE III—EXPANDING INNOVATION AND TECHNOLOGY

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

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

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

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

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

TITLE IV—IDENTIFYING THE CHRONICALLY ILL POPULATION

Sec. 401. Providing flexibility for beneficiaries to be part of an accountable care organization.

TITLE V—EMPOWERING INDIVIDUALS AND CAREGIVERS IN CARE DELIVERY

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

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

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

Sec. 601. Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes.

Sec. 602. GAO study and report on improving medication synchronization.

Sec. 603. GAO study and report on impact of obesity drugs on patient health and spending.

Sec. 604. HHS study and report on long-term risk factors for chronic conditions among Medicare beneficiaries.

TITLE VII—OFFSETS

Sec. 701. Medicare Improvement Fund.

Sec. 702. Medicaid Improvement Fund

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

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

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

7 (1) in subsection (e)—

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

10 (B) in paragraph (5), by striking “10,000”
 11 and inserting “15,000”;

12 (2) in subsection (g), in the first sentence, by
 13 inserting “, including, to the extent practicable, the
 14 use of electronic health information systems as de-
 15 scribed in subsection (b)(1)(A)(vi),” after “pro-
 16 gram”; and

17 (3) in subsection (i)(A), by striking “will not re-
 18 ceive an incentive payment for the second of 2” and
 19 inserting “did not achieve savings for the third of
 20 3”.

1 **SEC. 102. EXPANDING ACCESS TO HOME DIALYSIS THER-**
 2 **APY.**

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

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

7 (2) in clause (ii), as redesignated by subpara-
 8 graph (A), strike “on a comprehensive” and insert
 9 “subject to subparagraph (B), on a comprehensive”;
 10 (3) by striking “With respect to” and inserting
 11 “(A) With respect to”; and

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

14 “(B) For purposes of subparagraph (A)(ii), an indi-
 15 vidual determined to have end stage renal disease receiv-
 16 ing home dialysis may choose to receive monthly end stage
 17 renal disease-related clinical assessments furnished on or
 18 after January 1, 2019, via telehealth if the individual re-
 19 ceives a face-to-face clinical assessment, without the use
 20 of telehealth, at least once every three consecutive
 21 months.”.

22 (b) ORIGINATING SITE REQUIREMENTS.—

23 (1) IN GENERAL.—Section 1834(m) of the So-
 24 cial Security Act (42 U.S.C. 1395m(m)) is amend-
 25 ed—

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

3 “(IX) A renal dialysis facility,
4 but only for purposes of section
5 1881(b)(3)(B).

6 “(X) The home of an individual,
7 but only for purposes of section
8 1881(b)(3)(B).”; and

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

11 “(5) TREATMENT OF HOME DIALYSIS MONTHLY
12 ESRD-RELATED VISIT.—The geographic require-
13 ments described in paragraph (4)(C)(i) shall not
14 apply with respect to telehealth services furnished on
15 or after January 1, 2019, for purposes of section
16 1881(b)(3)(B), at an originating site described in
17 subclause (VI), (IX), or (X) of paragraph
18 (4)(C)(ii).”.

19 (2) NO FACILITY FEE IF ORIGINATING SITE
20 FOR HOME DIALYSIS THERAPY IS THE HOME.—Sec-
21 tion 1834(m)(2)(B) of the Social Security (42
22 U.S.C. 1395m(m)(2)(B)) is amended—

23 (A) by redesignating clauses (i) and (ii) as
24 subclauses (I) and (II), and indenting appro-
25 priately;

1 (B) in subclause (II), as redesignated by
2 subparagraph (A), by striking “clause (i) or
3 this clause” and inserting “subclause (I) or this
4 subclause”;

5 (C) by striking “SITE.—With respect to”
6 and inserting “SITE.—

7 “(i) IN GENERAL.—Subject to clause
8 (ii), with respect to”; and

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

11 “(ii) NO FACILITY FEE IF ORIGI-
12 NATING SITE FOR HOME DIALYSIS THER-
13 APY IS THE HOME.—No facility fee shall
14 be paid under this subparagraph to an
15 originating site described in paragraph
16 (4)(C)(ii)(X).”.

17 (e) CONFORMING AMENDMENT.—Section 1881(b)(1)
18 of the Social Security Act (42 U.S.C. 1395rr(b)(1)) is
19 amended by striking “paragraph (3)(A)” and inserting
20 “paragraph (3)(A)(i)”.

1 **TITLE II—ADVANCING TEAM-**
 2 **BASED CARE**

3 **SEC. 201. PROVIDING CONTINUED ACCESS TO MEDICARE**
 4 **ADVANTAGE SPECIAL NEEDS PLANS FOR**
 5 **VULNERABLE POPULATIONS.**

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

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

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

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

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

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

18 “(8) **INCREASED INTEGRATION OF DUAL**
 19 **SNPS.**—

20 “(A) **DESIGNATED CONTACT.**—The Sec-
 21 retary, acting through the Federal Coordinated
 22 Health Care Office established under section
 23 2602 of the Patient Protection and Affordable
 24 Care Act, shall serve as a dedicated point of
 25 contact for States to address misalignments

1 that arise with the integration of specialized
 2 MA plans for special needs individuals de-
 3 scribed in subsection (b)(6)(B)(ii) under this
 4 paragraph and, consistent with such role,
 5 shall—

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

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

16 “(B) UNIFIED GRIEVANCES AND APPEALS
 17 PROCESS.—

18 “(i) IN GENERAL.—Not later than
 19 April 1, 2020, the Secretary shall establish
 20 procedures, to the extent feasible, unifying
 21 grievances and appeals procedures under
 22 sections 1852(f), 1852(g), 1902(a)(3),
 23 1902(a)(5), and 1932(b)(4) for items and
 24 services provided by specialized MA plans
 25 for special needs individuals described in

1 subsection (b)(6)(B)(ii) under this title
2 and title XIX. The Secretary shall solicit
3 comment in developing such procedures
4 from States, plans, beneficiaries and their
5 representatives, and other relevant stake-
6 holders.

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

11 “(I) adopt the provisions for the
12 enrollee that are most protective for
13 the enrollee and, to the extent feasible
14 as determined by the Secretary, are
15 compatible with unified timeframes
16 and consolidated access to external re-
17 view under an integrated process;

18 “(II) take into account dif-
19 ferences in State plans under title
20 XIX to the extent necessary;

21 “(III) be easily navigable by an
22 enrollee; and

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

1 “(iii) ELEMENTS DESCRIBED.—Both
2 unified appeals and unified grievance pro-
3 cedures shall include, as applicable, the fol-
4 lowing elements described in this clause:

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

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

21 “(III) Notices written in plain
22 language and available in a language
23 and format that is accessible to the
24 enrollee, including in non-English lan-

1 guages that are prevalent in the serv-
2 ice area of the specialized MA plan.

3 “(IV) Unified timeframes for
4 grievances and appeals processes,
5 such as an individual’s filing of a
6 grievance or appeal, a plan’s acknowl-
7 edgment and resolution of a grievance
8 or appeal, and notification of decisions
9 with respect to a grievance or appeal.

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

19 “(iv) CONTINUATION OF BENEFITS
20 PENDING APPEAL.—The unified procedures
21 under clause (i) shall, with respect to all
22 benefits under parts A and B and title
23 XIX subject to appeal under such proce-
24 dures, incorporate provisions under current
25 law and implementing regulations that pro-

1 vide continuation of benefits pending ap-
2 peal under this title and title XIX.

3 “(C) REQUIREMENT FOR UNIFIED GRIEV-
4 ANCES AND APPEALS.—For 2021 and subse-
5 quent years, the contract of a specialized MA
6 plan for special needs individuals described in
7 subsection (b)(6)(B)(ii) with a State Medicaid
8 agency under paragraph (3)(D) shall require
9 the use of unified grievances and appeals proce-
10 dures as described in subparagraph (B).

11 “(D) REQUIREMENTS FOR INTEGRA-
12 TION.—For 2021 and subsequent years, a spe-
13 cialized MA plan for special needs individuals
14 described in subsection (b)(6)(B)(ii) shall meet
15 one or more of the following requirements, to
16 the extent permitted under State law, for inte-
17 gration of benefits under this title and title
18 XIX:

19 “(i) The specialized MA plan must
20 meet the requirements of contracting with
21 the State Medicaid agency described in
22 paragraph (3)(D) in addition to coordi-
23 nating long-term services and supports or
24 behavioral health services, or both, by
25 meeting an additional minimum set of re-

1 requirements determined by the Secretary
2 through the Federal Coordinated Health
3 Care Office established under section 2602
4 of the Patient Protection and Affordable
5 Care Act based on input from stake-
6 holders, such as notifying the State in a
7 timely manner of hospitalizations, emer-
8 gency room visits, and hospital or nursing
9 home discharges of enrollees, assigning one
10 primary care provider for each enrollee, or
11 sharing data that would benefit the coordi-
12 nation of items and services under this
13 title and the State plan under title XIX.
14 Such minimum set of requirements must
15 be included in the contract of the special-
16 ized MA plan with the State Medicaid
17 agency under such paragraph.

18 “(ii) The specialized MA plan must
19 meet the requirements of a fully integrated
20 plan described in section
21 1853(a)(1)(B)(iv)(II) (other than the re-
22 quirement that the plan have similar aver-
23 age levels of frailty, as determined by the
24 Secretary, as the PACE program), or enter
25 into a capitated contract with the State

1 Medicaid agency to provide long-term serv-
2 ices and supports or behavioral health
3 services, or both.

4 “(iii) In the case where an individual
5 is enrolled in both the specialized MA plan
6 and a Medicaid managed care organization
7 (as defined in section 1903(m)(1)(A)) pro-
8 viding long term services and supports or
9 behavioral health services that have the
10 same parent organization, the parent orga-
11 nization offering both the specialized MA
12 plan and the Medicaid managed care plan
13 must assume clinical and financial respon-
14 sibility for benefits provided under this
15 title and title XIX.”.

16 (2) CONFORMING AMENDMENT TO RESPON-
17 SIBILITIES OF FEDERAL COORDINATED HEALTH
18 CARE OFFICE.—Section 2602(d) of the Patient Pro-
19 tection and Affordable Care Act (42 U.S.C.
20 1315b(d)) is amended by adding at the end the fol-
21 lowing new paragraphs:

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

1 needs individuals described in subsection
2 (b)(6)(B)(ii) of such section.

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

9 (c) IMPROVEMENTS TO SEVERE OR DISABLING
10 CHRONIC CONDITION SNPs.—

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

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

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

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

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

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

3 “(B) IMPROVEMENTS TO CARE MANAGE-
4 MENT REQUIREMENTS FOR SEVERE OR DIS-
5 ABLING CHRONIC CONDITION SNPS.—For 2020
6 and subsequent years, in the case of a special-
7 ized MA plan for special needs individuals de-
8 scribed in subsection (b)(6)(B)(iii), the require-
9 ments described in this paragraph include the
10 following:

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

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

22 “(iii) As part of the model of care
23 under clause (i) of subparagraph (A), the
24 results of the initial assessment and an-
25 nual reassessment under clause (ii)(I) of

1 such subparagraph of each individual en-
 2 rolled in the plan are addressed in the indi-
 3 vidual’s individualized care plan under
 4 clause (ii)(II) of such subparagraph.

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

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

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

21 (A) IN GENERAL.—Section
 22 1859(b)(6)(B)(iii) of the Social Security Act
 23 (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amend-
 24 ed—

1 (i) by striking “who have” and insert-
2 ing “who—

3 “(I) before January 1, 2022,
4 have”;

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

8 (iii) by adding at the end the fol-
9 lowing new subclause:

10 “(II) on or after January 1,
11 2022, have one or more comorbid and
12 medically complex chronic conditions
13 that is life threatening or significantly
14 limits overall health or function, have
15 a high risk of hospitalization or other
16 adverse health outcomes, and require
17 intensive care coordination and that is
18 listed under subsection (f)(9)(A).”.

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

24 “(9) LIST OF CONDITIONS FOR CLARIFICATION
25 OF THE DEFINITION OF A SEVERE OR DISABLING

1 CHRONIC CONDITIONS SPECIALIZED NEEDS INDI-
2 VIDUAL.—

3 “(A) IN GENERAL.—Not later than De-
4 cember 31, 2020, and every 5 years thereafter,
5 the Secretary shall convene a panel of clinical
6 advisors to establish and update a list of condi-
7 tions that meet each of the following criteria:

8 “(i) Conditions that meet the defini-
9 tion of a severe or disabling chronic condi-
10 tion under subsection (b)(6)(B)(iii) on or
11 after January 1, 2022.

12 “(ii) Conditions that require prescrip-
13 tion drugs, providers, and models of care
14 that are unique to the specific population
15 of enrollees in a specialized MA plan for
16 special needs individuals described in such
17 subsection on or after such date and—

18 “(I) as a result of access to, and
19 enrollment in, such a specialized MA
20 plan for special needs individuals, in-
21 dividuals with such condition would
22 have a reasonable expectation of slow-
23 ing or halting the progression of the
24 disease, improving health outcomes
25 and decreasing overall costs for indi-

1 viduals diagnosed with such condition
 2 compared to available options of care
 3 other than through such a specialized
 4 MA plan for special needs individuals;
 5 or

6 “(II) have a low prevalence in the
 7 general population of beneficiaries
 8 under this title or a disproportionately
 9 high per-beneficiary cost under this
 10 title.

11 “(B) REQUIREMENT.—In establishing and
 12 updating the list under subparagraph (A), the
 13 panel shall take into account the availability of
 14 varied benefits, cost-sharing, and supplemental
 15 benefits under the model described in para-
 16 graph (2) of section 1859(h), including the ex-
 17 pansion under paragraph (1) of such section.”.

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

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

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

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

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

18 “(ii) take into consideration the im-
19 pact of such application on plans that
20 serve a disproportionate number of individ-
21 uals dually eligible for benefits under this
22 title and under title XIX;

23 “(iii) if quality measures are reported
24 at the plan level, ensure that MA plans are

1 not required to provide duplicative infor-
2 mation;

3 “(iv) ensure that such reporting does
4 not interfere with the collection of encoun-
5 ter data submitted by MA organizations or
6 the administration of any changes to the
7 program under this part as a result of the
8 collection of such data.

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

18 “(7) DETERMINATION OF FEASIBILITY OF
19 QUALITY MEASUREMENT AT THE PLAN LEVEL FOR
20 ALL MA PLANS.—

21 “(A) DETERMINATION OF FEASIBILITY.—
22 The Secretary shall determine the feasibility of
23 requiring reporting of data under section
24 1852(e) for, and applying under this subsection,

1 quality measures at the plan level for all MA
2 plans under this part.

3 “(B) CONSIDERATION OF CHANGE.—After
4 making a determination under subparagraph
5 (A), the Secretary shall consider requiring such
6 reporting and applying such quality measures
7 at the plan level as described in such subpara-
8 graph.”.

9 (e) GAO STUDY AND REPORT ON STATE-LEVEL IN-
10 TEGRATION BETWEEN DUAL SNPs AND MEDICAID.—

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

21 (A) The characteristics of States in which
22 the State agency responsible for administering
23 the State plan under such title XIX has a con-
24 tract with such a specialized MA plan and that
25 delivers long term services and supports under

1 the State plan under such title XIX through a
2 managed care program, including the require-
3 ments under such State plan with respect to
4 long term services and supports.

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

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

10 (ii) A plan that meets the require-
11 ments described in subsection (f)(3)(D) of
12 such section 1859.

13 (iii) A plan described in clause (ii)
14 that also meets additional requirements es-
15 tablished by the State.

16 (C) The characteristics of individuals en-
17 rolled in such specialized MA plans.

18 (D) As practicable, the following with re-
19 spect to State programs for the delivery of long
20 term services and supports under such title
21 XIX through a managed care program:

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

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

6 (E) How the availability and variation of
7 integration arrangements of such specialized
8 MA plans offered in States affects spending,
9 service delivery options, access to community-
10 based care, and utilization of care.

11 (F) The efforts of State Medicaid pro-
12 grams to transition dually-eligible beneficiaries
13 receiving long term services and supports
14 (LTSS) from institutional settings to home and
15 community-based settings and related financial
16 impacts of such transitions.

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

1 **TITLE III—EXPANDING**
2 **INNOVATION AND TECHNOLOGY**

3 **SEC. 301. ADAPTING BENEFITS TO MEET THE NEEDS OF**
4 **CHRONICALLY ILL MEDICARE ADVANTAGE**
5 **ENROLLEES.**

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

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

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

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

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

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

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

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

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

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

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

1 “(i) IN GENERAL.—For plan year
2 2020 and subsequent plan years, in addi-
3 tion to any supplemental health care bene-
4 fits otherwise provided under this para-
5 graph, an MA plan may provide supple-
6 mental benefits described in clause (ii) to
7 a chronically ill enrollee (as defined in
8 clause (iii)).

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

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

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

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

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

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

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

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

19 (b) GAO STUDY AND REPORT.—

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

1 available, such study shall include an analysis of the
2 following:

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

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

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

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

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

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

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

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

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

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

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

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

19 “(1) MA PLAN OPTION.—For plan year 2020
 20 and subsequent plan years, subject to the require-
 21 ments of paragraph (3), an MA plan may provide
 22 additional telehealth benefits (as defined in para-
 23 graph (2)) to individuals enrolled under this part.

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

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

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

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

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

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

1 “(B) PUBLIC COMMENT.—Not later than
2 November 30, 2018, the Secretary shall solicit
3 comments on—

4 “(i) what types of items and services
5 (including those provided through supple-
6 mental health care benefits) should be con-
7 sidered to be additional telehealth benefits;
8 and

9 “(ii) the requirements for the provi-
10 sion or furnishing of such benefits (such as
11 licensure, training, and coordination re-
12 quirements).

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

18 “(A) Physician or practitioner licensure
19 and other requirements such as specific train-
20 ing.

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

24 “(C) Such other areas as determined by
25 the Secretary.

1 “(4) ENROLLEE CHOICE.—If an MA plan pro-
2 vides a service as an additional telehealth benefit (as
3 defined in paragraph (2))—

4 “(A) the MA plan shall also provide access
5 to such benefit through an in-person visit (and
6 not only as an additional telehealth benefit);
7 and

8 “(B) an individual enrollee shall have dis-
9 cretion as to whether to receive such service
10 through the in-person visit or as an additional
11 telehealth benefit.

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

17 “(6) CONSTRUCTION.—Nothing in this sub-
18 section shall be construed as affecting the require-
19 ment under subsection (a)(1) that MA plans provide
20 enrollees with items and services (other than hospice
21 care) for which benefits are available under parts A
22 and B, including benefits available under section
23 1834(m).”.

24 (b) CLARIFICATION REGARDING INCLUSION IN BID
25 AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Se-

1 curity Act (42 U.S.C. 1395w-24(a)(6)(A)(ii)(I)) is
 2 amended by inserting “, including, for plan year 2020 and
 3 subsequent plan years, the provision of additional tele-
 4 health benefits as described in section 1852(m)” before
 5 the semicolon at the end.

6 **SEC. 304. PROVIDING ACCOUNTABLE CARE ORGANIZA-**
 7 **TIONS THE ABILITY TO EXPAND THE USE OF**
 8 **TELEHEALTH.**

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

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

14 “(1) IN GENERAL.—In the case of telehealth
 15 services for which payment would otherwise be made
 16 under this title furnished on or after January 1,
 17 2020, for purposes of this subsection only, the fol-
 18 lowing shall apply with respect to such services fur-
 19 nished by a physician or practitioner participating in
 20 an applicable ACO (as defined in paragraph (2)) to
 21 a Medicare fee-for-service beneficiary assigned to the
 22 applicable ACO:

23 “(A) INCLUSION OF HOME AS ORIGINATING
 24 SITE.—Subject to paragraph (3), the home of a

1 beneficiary shall be treated as an originating
2 site described in section 1834(m)(4)(C)(ii).

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

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

11 “(A) APPLICABLE ACO.—The term ‘appli-
12 cable ACO’ means an ACO participating in a
13 model tested or expanded under section 1115A
14 or under this section—

15 “(i) that operates under a two-sided
16 model—

17 “(I) described in section
18 425.600(a) of title 42, Code of Fed-
19 eral Regulations; or

20 “(II) tested or expanded under
21 section 1115A; and

22 “(ii) for which Medicare fee-for-serv-
23 ice beneficiaries are assigned to the ACO
24 using a prospective assignment method, as
25 determined appropriate by the Secretary.

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

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

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

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

18 (b) STUDY AND REPORT.—

19 (1) STUDY.—

20 (A) IN GENERAL.—The Secretary of
21 Health and Human Services (in this subsection
22 referred to as the “Secretary”) shall conduct a
23 study on the implementation of section 1899(l)
24 of the Social Security Act, as added by sub-
25 section (a). Such study shall include an analysis

1 of the utilization of, and expenditures for, tele-
 2 health services under such section.

3 (B) COLLECTION OF DATA.—The Sec-
 4 retary may collect such data as the Secretary
 5 determines necessary to carry out the study
 6 under this paragraph.

7 (2) REPORT.—Not later than January 1, 2026,
 8 the Secretary shall submit to Congress a report con-
 9 taining the results of the study conducted under
 10 paragraph (1), together with recommendations for
 11 such legislation and administrative action as the
 12 Secretary determines appropriate.

13 **SEC. 305. EXPANDING THE USE OF TELEHEALTH FOR INDI-**
 14 **VIDUALS WITH STROKE.**

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

19 “(6) TREATMENT OF STROKE TELEHEALTH
 20 SERVICES.—

21 “(A) NON-APPLICATION OF ORIGINATING
 22 SITE REQUIREMENTS.—The requirements de-
 23 scribed in paragraph (4)(C) shall not apply with
 24 respect to telehealth services furnished on or
 25 after January 1, 2021, for purposes of evalua-

1 tion of an acute stroke, as determined by the
2 Secretary.

3 “(B) NO ORIGINATING SITE FACILITY
4 FEE.—In the case of an originating site that
5 does not meet the requirements described in
6 paragraph (4)(C), the Secretary shall not pay an
7 originating site facility fee (as described in
8 paragraph (2)(B)) to the originating site with
9 respect to such telehealth services.”.

10 **TITLE IV—IDENTIFYING THE**
11 **CHRONICALLY ILL POPULATION**

12 **SEC. 401. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO**
13 **BE PART OF AN ACCOUNTABLE CARE ORGA-**
14 **NIZATION.**

15 Section 1899(c) of the Social Security Act (42 U.S.C.
16 1395jjj(c)) is amended—

17 (1) by redesignating paragraphs (1) and (2) as
18 subparagraphs (A) and (B), respectively, and indent-
19 ing appropriately;

20 (2) by striking “ACOs.—The Secretary” and
21 inserting “ACOs.—

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

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

1 “(2) PROVIDING FLEXIBILITY.—

2 “(A) CHOICE OF PROSPECTIVE ASSIGN-
3 MENT.—For each agreement period (effective
4 for agreements entered into or renewed on or
5 after January 1, 2020), in the case where an
6 ACO established under the program is in a
7 Track that provides for the retrospective assign-
8 ment of Medicare fee-for-service beneficiaries to
9 the ACO, the Secretary shall permit the ACO
10 to choose to have Medicare fee-for-service bene-
11 ficiaries assigned prospectively, rather than ret-
12 rospectively, to the ACO for an agreement pe-
13 riod.

14 “(B) ASSIGNMENT BASED ON VOLUNTARY
15 IDENTIFICATION BY MEDICARE FEE-FOR-SERV-
16 ICE BENEFICIARIES.—

17 “(i) IN GENERAL.—For performance
18 year 2018 and each subsequent perform-
19 ance year, if a system is available for elec-
20 tronic designation, the Secretary shall per-
21 mit a Medicare fee-for-service beneficiary
22 to voluntarily identify an ACO professional
23 as the primary care provider of the bene-
24 ficiary for purposes of assigning such bene-

1 beneficiary to an ACO, as determined by the
2 Secretary.

3 “(ii) NOTIFICATION PROCESS.—The
4 Secretary shall establish a process under
5 which a Medicare fee-for-service bene-
6 ficiary is—

7 “(I) notified of their ability to
8 make an identification described in
9 clause (i); and

10 “(II) informed of the process by
11 which they may make and change
12 such identification.

13 “(iii) SUPERSEDING CLAIMS-BASED
14 ASSIGNMENT.—A voluntary identification
15 by a Medicare fee-for-service beneficiary
16 under this subparagraph shall supersede
17 any claims-based assignment otherwise de-
18 termined by the Secretary.”.

1 **TITLE V—EMPOWERING INDIVIDUALS AND CAREGIVERS IN**
 2 **CARE DELIVERY**

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

7 (a) IN GENERAL.—Section 1899 of the Social Security Act (42 U.S.C. 1395jjj), as amended by section 9 304(a), is amended—

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

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

17 (2) by adding at the end the following new subsection:
 18

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

22 “(1) **PROGRAM.**—

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

1 ACO participating under this section under a
2 payment model described in clause (i) or (ii) of
3 paragraph (2)(B) may apply to establish an
4 ACO Beneficiary Incentive Program to provide
5 incentive payments to such beneficiaries who
6 are furnished qualifying services in accordance
7 with this subsection. The Secretary shall permit
8 such an ACO to establish such a program at
9 the Secretary's discretion and subject to such
10 requirements, including program integrity re-
11 quirements, as the Secretary determines nec-
12 essary.

13 “(B) IMPLEMENTATION.—The Secretary
14 shall implement this subsection on a date deter-
15 mined appropriate by the Secretary. Such date
16 shall be no earlier than January 1, 2019, and
17 no later than January 1, 2020.

18 “(2) CONDUCT OF PROGRAM.—

19 “(A) DURATION.—Subject to subpara-
20 graph (H), an ACO Beneficiary Incentive Pro-
21 gram established under this subsection shall be
22 conducted for such period (of not less than 1
23 year) as the Secretary may approve.

24 “(B) SCOPE.—An ACO Beneficiary Incen-
25 tive Program established under this subsection

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

5 “(i) With respect to the Track 2 and
6 Track 3 payment models described in sec-
7 tion 425.600(a) of title 42, Code of Fed-
8 eral Regulations (or in any successor regu-
9 lation), Medicare fee-for-service bene-
10 ficiaries who are preliminarily prospectively
11 or prospectively assigned (or otherwise as-
12 signed, as determined by the Secretary) to
13 the ACO.

14 “(ii) With respect to any future pay-
15 ment models involving two-sided risk,
16 Medicare fee-for-service beneficiaries who
17 are assigned to the ACO, as determined by
18 the Secretary.

19 “(C) QUALIFYING SERVICE.—For purposes
20 of this subsection, a qualifying service is a pri-
21 mary care service, as defined in section 425.20
22 of title 42, Code of Federal Regulations (or in
23 any successor regulation), with respect to which
24 coinsurance applies under part B, furnished
25 through an ACO by—

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

7 “(ii) an ACO professional described in
8 subsection (h)(1)(B); or

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

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

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

23 “(ii) in the same amount for each
24 Medicare fee-for-service beneficiary de-
25 scribed in clause (i) or (ii) of subparagraph

1 (B) without regard to enrollment of such a
2 beneficiary in a medicare supplemental pol-
3 icy (described in section 1882(g)(1)), in a
4 State Medicaid plan under title XIX or a
5 waiver of such a plan, or in any other
6 health insurance policy or health benefit
7 plan;

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

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

17 “(E) NO SEPARATE PAYMENTS FROM THE
18 SECRETARY.—The Secretary shall not make
19 any separate payment to an ACO for the costs,
20 including incentive payments, of carrying out
21 an ACO Beneficiary Incentive Program estab-
22 lished under this subsection. Nothing in this
23 subparagraph shall be construed as prohibiting
24 an ACO from using shared savings received

1 under this section to carry out an ACO Bene-
2 ficiary Incentive Program.

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

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

20 “(H) TERMINATION.—The Secretary may
21 terminate an ACO Beneficiary Incentive Pro-
22 gram established under this subsection at any
23 time for reasons determined appropriate by the
24 Secretary.

1 “(3) EXCLUSION OF INCENTIVE PAYMENTS.—
2 Any payment made under an ACO Beneficiary In-
3 centive Program established under this subsection
4 shall not be considered income or resources or other-
5 wise taken into account for purposes of—

6 “(A) determining eligibility for benefits or
7 assistance (or the amount or extent of benefits
8 or assistance) under any Federal program or
9 under any State or local program financed in
10 whole or in part with Federal funds; or

11 “(B) any Federal or State laws relating to
12 taxation.”;

13 (3) in subsection (e), by inserting “, including
14 an ACO Beneficiary Incentive Program under sub-
15 sections (b)(2)(I) and (m)” after “the program”;
16 and

17 (4) in subsection (g)(6), by inserting “or of an
18 ACO Beneficiary Incentive Program under sub-
19 sections (b)(2)(I) and (m)” after “under subsection
20 (d)(4)”.

21 (b) AMENDMENT TO SECTION 1128B.—Section
22 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a-
23 7b(b)(3)) is amended—

24 (1) by striking “and” at the end of subpara-
25 graph (I);

1 (2) by striking the period at the end of sub-
2 paragraph (J) and inserting “; and”; and

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

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

13 (c) EVALUATION AND REPORT.—

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

1 (2) REPORT.—Not later than October 1, 2023,
2 the Secretary shall submit to Congress a report con-
3 taining the results of the evaluation under para-
4 graph (1), together with recommendations for such
5 legislation and administrative action as the Sec-
6 retary determines appropriate.

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

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

17 (1) The frequency with which services similar to
18 longitudinal comprehensive care planning services
19 are furnished to Medicare beneficiaries, which pro-
20 viders of services and suppliers are furnishing those
21 services, whether Medicare reimbursement is being
22 received for those services, and, if so, through which
23 codes those services are being reimbursed.

24 (2) Whether, and the extent to which, longitu-
25 dinal comprehensive care planning services would

1 overlap, and could therefore result in duplicative
2 payment, with services covered under the hospice
3 benefit as well as the chronic care management code,
4 evaluation and management codes, or other codes
5 that already exist under part B of the Medicare pro-
6 gram.

7 (3) Any barriers to hospitals, skilled nursing fa-
8 cilities, hospice programs, home health agencies, and
9 other applicable providers working with a Medicare
10 beneficiary to engage in the care planning process
11 and complete the necessary documentation to sup-
12 port the treatment and care plan of the beneficiary
13 and provide such documentation to other providers
14 and the beneficiary or the beneficiary's representa-
15 tive.

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

21 (5) Potential options for ensuring that applica-
22 ble providers are notified of a patient's existing lon-
23 gitudinal care plan and that applicable providers
24 consider that plan in making their treatment deci-

1 sions, and what the challenges might be in imple-
2 menting such options.

3 (6) Stakeholder’s views on the need for the de-
4 velopment of quality metrics with respect to longitu-
5 dinal comprehensive care planning services, such as
6 measures related to—

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

11 (B) the effectiveness and patient-
12 centeredness of the care plan in organizing de-
13 livery of services consistent with the plan;

14 (C) the availability of the care plan and as-
15 sociated documentation to other providers that
16 care for the beneficiary; and

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

21 (7) Stakeholder’s views on how such quality
22 metrics would provide information on—

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

25 (B) the documentation of the care plan;

1 (C) services furnished to the beneficiary;
2 and

3 (D) outcomes of treatment.

4 (8) Stakeholder's views on—

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

9 (B) the types of providers of services and
10 suppliers that should be included in the inter-
11 disciplinary team of an applicable provider; and

12 (C) the characteristics of Medicare bene-
13 ficiaries that would be most appropriate to re-
14 ceive longitudinal comprehensive care planning
15 services, such as individuals with advanced dis-
16 ease and individuals who need assistance with
17 multiple activities of daily living.

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

21 (b) REPORT.—Not later than 18 months after the
22 date of the enactment of this Act, the Comptroller General
23 shall submit to Congress a report containing the results
24 of the study conducted under subsection (a), together with

1 recommendations for such legislation and administrative
2 action as the Comptroller General determines appropriate.

3 (c) DEFINITIONS.—In this section:

4 (1) APPLICABLE PROVIDER.—The term “applicable provider” means a hospice program (as defined
5 in subsection (dd)(2) of section 1861 of the Social
6 Security Act (42 U.S.C. 1395ww)) or other provider
7 of services (as defined in subsection (u) of such section)
8 or supplier (as defined in subsection (d) of
9 such section) that—
10

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

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

16 (2) COMPTROLLER GENERAL.—The term
17 “Comptroller General” means the Comptroller General
18 of the United States.

19 (3) INTERDISCIPLINARY TEAM.—The term
20 “interdisciplinary team” means a group that—

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

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

1 (C) may include other direct care per-
2 sonnel.

3 (4) LONGITUDINAL COMPREHENSIVE CARE
4 PLANNING SERVICES.—The term “longitudinal com-
5 prehensive care planning services” means a vol-
6 untary shared decisionmaking process that is fur-
7 nished by an applicable provider through an inter-
8 disciplinary team and includes a conversation with
9 Medicare beneficiaries who have received a diagnosis
10 of a serious or life-threatening illness. The purpose
11 of such services is to discuss a longitudinal care plan
12 that addresses the progression of the disease, treat-
13 ment options, the goals, values, and preferences of
14 the beneficiary, and the availability of other re-
15 sources and social supports that may reduce the
16 beneficiary’s health risks and promote self-manage-
17 ment and shared decisionmaking.

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

1 **TITLE VI—OTHER POLICIES TO**
2 **IMPROVE CARE FOR THE**
3 **CHRONICALLY ILL**

4 **SEC. 601. PROVIDING PRESCRIPTION DRUG PLANS WITH**
5 **PARTS A AND B CLAIMS DATA TO PROMOTE**
6 **THE APPROPRIATE USE OF MEDICATIONS**
7 **AND IMPROVE HEALTH OUTCOMES.**

8 Section 1860D–4(c) of the Social Security Act (42
9 U.S.C. 1395w–104(e)) is amended by adding at the end
10 the following new paragraph:

11 “(6) PROVIDING PRESCRIPTION DRUG PLANS
12 WITH PARTS A AND B CLAIMS DATA TO PROMOTE
13 THE APPROPRIATE USE OF MEDICATIONS AND IM-
14 PROVE HEALTH OUTCOMES.—

15 “(A) PROCESS.—Subject to subparagraph
16 (B), the Secretary shall establish a process
17 under which a PDP sponsor of a prescription
18 drug plan may submit a request for the Sec-
19 retary to provide the sponsor, on a periodic
20 basis and in an electronic format, beginning in
21 plan year 2020, data described in subparagraph
22 (D) with respect to enrollees in such plan. Such
23 data shall be provided without regard to wheth-
24 er such enrollees are described in clause (ii) of
25 paragraph (2)(A).

1 “(B) PURPOSES.—A PDP sponsor may
2 use the data provided to the sponsor pursuant
3 to subparagraph (A) for any of the following
4 purposes:

5 “(i) To optimize therapeutic outcomes
6 through improved medication use, as such
7 phrase is used in clause (i) of paragraph
8 (2)(A).

9 “(ii) To improving care coordination
10 so as to prevent adverse health outcomes,
11 such as preventable emergency department
12 visits and hospital readmissions.

13 “(iii) For any other purpose deter-
14 mined appropriate by the Secretary.

15 “(C) LIMITATIONS ON DATA USE.—A PDP
16 sponsor shall not use data provided to the spon-
17 sor pursuant to subparagraph (A) for any of
18 the following purposes:

19 “(i) To inform coverage determina-
20 tions under this part.

21 “(ii) To conduct retroactive reviews of
22 medically accepted indications determina-
23 tions.

24 “(iii) To facilitate enrollment changes
25 to a different prescription drug plan or an

1 MA–PD plan offered by the same parent
2 organization.

3 “(iv) To inform marketing of benefits.

4 “(v) For any other purpose that the
5 Secretary determines is necessary to in-
6 clude in order to protect the identity of in-
7 dividuals entitled to, or enrolled for, bene-
8 fits under this title and to protect the se-
9 curity of personal health information.

10 “(D) DATA DESCRIBED.—The data de-
11 scribed in this clause are standardized extracts
12 (as determined by the Secretary) of claims data
13 under parts A and B for items and services fur-
14 nished under such parts for time periods speci-
15 fied by the Secretary. Such data shall include
16 data as current as practicable.”.

17 **SEC. 602. GAO STUDY AND REPORT ON IMPROVING MEDI-**
18 **CATION SYNCHRONIZATION.**

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

1 individuals may receive multiple prescriptions on the same
2 day to facilitate comprehensive counseling and promote
3 medication adherence. The study shall include a analysis
4 of the following:

5 (1) The extent to which pharmacies have adopt-
6 ed such programs.

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

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

16 (4) What is known about how such programs
17 affect patient medication adherence and overall pa-
18 tient health outcomes, including if adherence and
19 outcomes vary by patient subpopulations, such as
20 disease state and socioeconomic status.

21 (5) What is known about overall patient satis-
22 faction with such programs and satisfaction with
23 such programs, including within patient subpopula-
24 tions, such as disease state and socioeconomic sta-
25 tus.

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

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

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

12 **SEC. 603. GAO STUDY AND REPORT ON IMPACT OF OBESITY**
13 **DRUGS ON PATIENT HEALTH AND SPENDING.**

14 (a) STUDY.—The Comptroller General of the United
15 States (in this section referred to as the “Comptroller
16 General”) shall, to the extent data are available, conduct
17 a study on the use of prescription drugs to manage the
18 weight of obese patients and the impact of coverage of
19 such drugs on patient health and on health care spending.
20 Such study shall examine the use and impact of these obe-
21 sity drugs in the non-Medicare population and for Medi-
22 care beneficiaries who have such drugs covered through
23 an MA–PD plan (as defined in section 1860D–1(a)(3)(C)
24 of the Social Security Act (42 U.S.C. 1395w–

1 101(a)(3)(C))) as a supplemental health care benefit. The
2 study shall include an analysis of the following:

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

5 (2) The utilization of obesity drugs.

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

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

14 (5) Physician considerations and attitudes re-
15 lated to prescribing obesity drugs.

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

19 (7) What is known about the extent to which
20 individuals who take obesity drugs adhere to the pre-
21 scribed regimen.

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

1 (9) What is known about the subsequent impact
2 such drugs have on medical services that are directly
3 related to obesity, including with respect to sub-
4 populations determined based on the extent of obe-
5 sity.

6 (10) What is known about the spending associ-
7 ated with the care of individuals who take obesity
8 drugs, compared to the spending associated with the
9 care of individuals who do not take such drugs.

10 (b) REPORT.—Not later than 18 months after the
11 date of the enactment of this Act, the Comptroller General
12 shall submit to Congress a report containing the results
13 of the study under subsection (a), together with rec-
14 ommendations for such legislation and administrative ac-
15 tion as the Comptroller General determines appropriate.

16 **SEC. 604. HHS STUDY AND REPORT ON LONG-TERM RISK**
17 **FACTORS FOR CHRONIC CONDITIONS AMONG**
18 **MEDICARE BENEFICIARIES.**

19 (a) STUDY.—The Secretary of Health and Human
20 Services (in this section referred to as the “Secretary”)
21 shall conduct a study on long-term cost drivers to the
22 Medicare program, including obesity, tobacco use, mental
23 health conditions, and other factors that may contribute
24 to the deterioration of health conditions among individuals
25 with chronic conditions in the Medicare population. The

1 study shall include an analysis of any barriers to collecting
2 and analyzing such information and how to remove any
3 such barriers (including through legislation and adminis-
4 trative actions).

5 (b) REPORT.—Not later than 18 months after the
6 date of the enactment of this Act, the Secretary shall sub-
7 mit to Congress a report containing the results of the
8 study under subsection (a), together with recommenda-
9 tions for such legislation and administrative action as the
10 Secretary determines appropriate. The Secretary shall also
11 post such report on the Internet website of the Depart-
12 ment of Health and Human Services.

13 **TITLE VII—OFFSETS**

14 **SEC. 701. MEDICARE IMPROVEMENT FUND.**

15 Section 1898(b)(1) of the Social Security Act (42
16 U.S.C. 1395iii(b)(1)) is amended by striking
17 “\$270,000,000” and inserting “\$0”.

1 **SEC. 702. MEDICAID IMPROVEMENT FUND.**

2 Section 1941(b)(1) of the Social Security Act (42
3 U.S.C. 1396w-1(b)(1)) is amended by striking
4 “\$5,000,000” and inserting “\$0”.

Passed the Senate September 26, 2017.

Attest:

JULIE E. ADAMS,

Secretary.