TITLE III – CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE

Subtitle A – Receiving High Quality Care in the Home

Section 50301. Extending the Independence at Home Demonstration Program. This section would extend and expand the Medicare Independence at Home demonstration to provide a broader base of experience to inform future legislative efforts. Specifically, it would extend the length of the demonstration by two years; increase the cap on the total number of participating beneficiaries from 10,000 to 15,000; and give practices three years to generate savings against their spending targets.

Section 50302. Expanding access to home dialysis therapy. This section would expand the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth, beginning January 1, 2019. Specifically, it would expand the number of originating sites from which the beneficiary can have a telehealth assessment with his or her clinician to include freestanding dialysis facilities and the patient’s
home and eliminate any geographic restriction for all originating sites. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home. A beneficiary would be required to receive the first three clinical assessments and at least one of every three assessments thereafter through an in person face-to-face encounter. Providers would be allowed to furnish equipment to facilitate telehealth to beneficiaries receiving home dialysis in certain situations.

Subtitle B – Advancing Team-Based Care

Section 50311. Providing continued access to Medicare Advantage special needs plans for vulnerable populations. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established a new Medicare Advantage (MA) coordinated care plan to provide services for individuals with special needs. Special needs plans (SNPs) are permitted to target enrollment to one or more types of special needs individuals, including those who are (1) institutionalized, (2) dually eligible for both Medicare and Medicaid, or (3) living with severe or disabling chronic conditions. Among other changes, the Affordable Care Act extended SNP authority through December 31, 2013, and temporarily extended authority through the end of 2012 for dual eligible SNPs without contracts with state Medicaid programs to continue to operate, but in their current service areas. After 2012, dual eligible SNPs, new and renewing, were required to have contracts with state Medicaid agencies. Several subsequent laws have extended SNP authority without interruption; most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

In this section, the Medicare-Medicaid Coordination Office would be directed to serve as a dedicated point of contact for states to assist with Medicare and Medicaid integration efforts, and the Secretary would be required to work through this office to establish a unified grievances and appeals process for individuals enrolled in a D-SNP. This section would permanently authorize the I-SNP, D-SNP and C-SNP, if certain requirements are met. By 2021, a D-SNP contract would be required to have a unified grievances and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid long-term services and supports and/or behavioral health services by meeting one of three requirements. Failure to meet one of the three integration requirements would result in suspension of enrollment. MedPAC, in consultation with MACPAC, would be required to conduct a study and report to Congress on the quality of D-SNPs. Beginning in 2020, a C-SNP would be required to meet additional requirements to improve care management for the beneficiaries with severe or disabling chronic conditions enrolled in the plan. By January 1, 2022, and every five years thereafter, the Secretary would be required to update the list of chronic conditions eligible for participation in a C-SNP. The updated list must include HIV/AIDS, end-stage renal disease, and chronic and disabling mental illness. The Secretary may consider implementing the quality star rating system at the plan level for SNPs and all MA plans. GAO would be instructed to conduct a study and report on state-level integration between D-SNPs and Medicaid within two years of enactment.

Subtitle C – Expanding Innovation and Technology
Section 50321. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees. Under Medicare Advantage (MA) private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll. Unlike original Medicare, where providers are paid for each item or service provided to a beneficiary, an MA plan receives the same capitated monthly payment regardless of how many or few services a beneficiary actually uses. The plan is at-risk if aggregate costs for its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing. Currently, an MA plan must offer the same benefit package to all of its enrollees. The Centers for Medicare and Medicaid Innovations (CMMI) is currently testing a model to allow greater flexibility for an MA plan to meet the needs of chronically ill enrollees. CMS has also proposed a regulation that would permit MA plans to offer a benefit package that includes different cost-sharing requirements or benefits to help MA plans better serve the most vulnerable enrollees.

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

Section 50322. Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees. All Medicare Advantage (MA) plans must offer required Medicare benefits (except hospice) and may offer additional or supplemental benefits. Mandatory supplemental benefits are covered by the MA plan for every person enrolled in the plan and are paid for either through plan rebates, a beneficiary premium, or cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollee may choose to pay an additional amount to receive coverage of the optional benefit; optional benefits cannot be financed through plan rebates.

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

1. Additional inpatient hospital days in an acute care or psychiatric facility,
2. Acupuncture or alternative therapies,
3. Counseling services,
4. Fitness benefit,
5. Enhanced disease management, and
6. Remote Access Technologies (including Web/Phone based technologies).

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

**Section 50323. Increasing convenience for Medicare Advantage enrollees through telehealth.** Telehealth is the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, and other health care delivery functions. While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program recognizes and pays for only certain Part B telehealth services. These services must be either (1) remote patient and physician/professional face-to-face services delivered via a telecommunications system (e.g., live video conferencing), or (2) non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services in the case of any Federal telemedicine demonstration program in Alaska or Hawaii. Typically, Medicare coverage for remote face-to-face services includes payments (1) to physicians or other professionals (at the distant site) for the telehealth consultation, and (2) to the facility where the patient is located (the originating site).

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

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

**Section 50324. Providing accountable care organizations the ability to expand the use of telehealth.** While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program restricts telehealth payments by the type of services provided, the geographic location where the services are delivered, the type of institution delivering the services, and the type of health provider. While there is nothing
to preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare. Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs. Telehealth may have the potential to replace some face-to-face office visits, reduce emergency room visits, and prevent hospitalizations. Telehealth may also keep beneficiaries in closer, more consistent contact with providers.

This section would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective assignment and remains at two-sided risk), MSSP Track III, and two-sided risk ACO models with prospective assignment that are tested or expanded through the Center for Medicare & Medicaid Innovation (CMMI) as determined appropriate by the Secretary. This provision would (1) eliminate the geographic component of the originating site requirement, (2) allow beneficiaries assigned to the approved MSSP and ACO programs to receive currently allowable telehealth services in the home, and (3) ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare’s physician fee schedule, with limited exceptions. To be eligible for Medicare payment, the beneficiary must be located at an originating site that is either (1) one of the approved sites listed in Section 1834(m)(4)(C)(ii) of the Social Security Act, or (2) the beneficiary’s place of residence. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home.

**Section 50325. Expanding the use of telehealth for individuals with stroke.** This section would expand the ability of patients presenting with stroke symptoms to receive a timely consultation to determine the best course of treatment through telehealth, beginning January 1, 2019. Specifically, it would eliminate the geographic restriction as to permit payment to physicians furnishing the telehealth consultation service in all areas of the country. Medicare would not provide a separate originating site payment to newly eligible originating sites.

**Subtitle D – Identifying the Chronically Ill Population**

**Section 50331. Providing flexibility for beneficiaries to be part of an accountable care organization.** Medicare fee-for-service beneficiaries are assigned to ACOs based on their utilization of primary care services provided by a physician who is an ACO provider and/or supplier. Beneficiaries currently do not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider), but are notified if their primary care provider is an ACO participant. Beneficiaries who receive at least one primary care service from a primary care physician within the ACO may be assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO, but who receive at least one primary care service from any physician within the ACO, are assigned to that ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians.

The manner in which Medicare fee-for-service beneficiaries are assigned to an ACO affects how the ACO can tailor care for its beneficiaries and how the ACO is evaluated. Under current
Centers for Medicare & Medicaid (CMS) rules, Medicare determines the method of beneficiary attribution, rather than giving ACOs the option to choose the assignment methodology that best fits their model of care. Medicare fee-for-service beneficiaries can be assigned to an ACO either retrospectively or prospectively depending on the ACO’s track. Prospective assignment allows ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care. Retrospective assignment ensures that ACOs are held accountable for the spending only of those beneficiaries who receive most of their primary care services from ACO providers, but they may not know who those beneficiaries are until the end of the year.

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

Subtitle E – Empowering Individuals and Caregivers in Care Delivery

Section 50341. Eliminating barriers to care coordination under accountable care organizations. ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, federally qualified health centers, rural health clinics, and others. In the Medicare Shared Savings Program (MSSP) specifically, ACOs are designed to provide incentives to providers to manage care across the continuum by reducing health care costs while meeting quality performance standards. The ACO mission is to ensure that patients, especially the chronically ill, receive the right care at the right time in the right care setting, while avoiding unnecessary duplication of services and preventing medical errors. Delaying or forgoing preventive care – especially care related to chronic disease management – may lead to increased costs and poor health outcomes. ACOs are accountable for the health outcomes and overall costs of their attributed beneficiaries. As a result, ACO aligned beneficiaries could be encouraged to seek out preventive care or chronic disease management if the cost to access those services is manageable.

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

Section 50342. GAO study and report on longitudinal comprehensive care planning services under Medicare Part B. This section would direct Government Accountability Office (GAO) to submit a report to Congress within 18 months of the date of enactment to inform the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness.

Subtitle F – Other Policies to Improve Care for the Chronically Ill

Section 50351. GAO study and report on improving medication synchronization. This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs.

Section 50352. GAO study and report on impact of obesity drugs on patient health and spending. This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the impact of the use of obesity drugs on patient health and spending.

Section 50353. HHS study and report on long-term risk factors for chronic conditions among Medicare beneficiaries. This section would require the Secretary to submit a report to Congress within 18 months of the date of enactment that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions.

Section 50354. Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes. Under current law, standalone prescription drug plans (PDPs) provide Medicare’s prescription drug benefit to fee-for-service (FFS) beneficiaries. Certain Medicare beneficiaries who meet criteria described in statute are eligible to enroll in medication therapy management (MTM) programs offered by PDPs. MTM’s purpose is to coordinate prescription drugs for high-cost beneficiaries. However, PDPs do not have access FFS utilization data that may aid the PDP in coordination efforts. This differs from MA-PDs which are responsible for providing both Medicare’s prescription drug benefit but also Medicare Part A and Part B’s medical benefits and has access to all relevant data.

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