

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.

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## 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.

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

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

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

1 (b) TABLE OF CONTENTS.—The table of contents of  
 2 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. GAO study and report on improving medication synchronization.

Sec. 602. GAO study and report on impact of obesity drugs on patient health and spending.

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”; and

12                   (2) in subsection (i), by striking “second of 2”  
 13                           and inserting “third of 3”.

14   **SEC. 102. EXPANDING ACCESS TO HOME DIALYSIS THER-**  
 15                           **APY.**

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

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

20                   (2) in clause (ii), as redesignated by subpara-  
 21                           graph (A), strike “on a comprehensive” and insert  
 22                           “subject to subparagraph (B), on a comprehensive”;

23                   (3) by striking “With respect to” and inserting  
 24                           “(A) With respect to”; and

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

3           “(B) For purposes of subparagraph (A)(ii), an indi-  
4 vidual determined to have end stage renal disease receiv-  
5 ing home dialysis may choose to receive the monthly end  
6 stage renal disease-related visits furnished on or after  
7 January 1, 2019, via telehealth if the individual receives  
8 a face-to-face visit, without the use of telehealth, at least  
9 once every three consecutive months.”.

10          (b) ORIGINATING SITE REQUIREMENTS.—

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

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

16                           “(IX) A renal dialysis facility,  
17 but only for purposes of section  
18 1881(b)(3)(B).

19                           “(X) The home of an individual,  
20 but only for purposes of section  
21 1881(b)(3)(B).”; and

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

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

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

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

11               (A) by redesignating clauses (i) and (ii) as  
12       subclauses (I) and (II), and indenting appro-  
13       priately;

14               (B) in subclause (II), as redesignated by  
15       subparagraph (A), by striking “clause (i) or  
16       this clause” and inserting “subclause (I) or this  
17       subclause”;

18               (C) by striking “SITE.—With respect to”  
19       and inserting “SITE.—

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

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

24               “(ii) NO FACILITY FEE IF ORIGI-  
25       NATING SITE FOR HOME DIALYSIS THER-

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

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

9 **TITLE II—ADVANCING TEAM-**  
 10 **BASED CARE**

11 **SEC. 201. PROVIDING CONTINUED ACCESS TO MEDICARE**  
 12 **ADVANTAGE SPECIAL NEEDS PLANS FOR**  
 13 **VULNERABLE POPULATIONS.**

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

17 (b) INCREASED INTEGRATION OF DUAL SNPs.—

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

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

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

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

1           “(8) INCREASED INTEGRATION OF DUAL  
2 SNPS.—

3           “(A) DESIGNATED CONTACT.—The Sec-  
4 retary, acting through the Federal Coordinated  
5 Health Care Office established under section  
6 2602 of the Patient Protection and Affordable  
7 Care Act, shall serve as a dedicated point of  
8 contact for States to address misalignments  
9 that arise with the integration of specialized  
10 MA plans for special needs individuals de-  
11 scribed in subsection (b)(6)(B)(ii) under this  
12 paragraph and, consistent with such role,  
13 shall—

14           “(i) establish a uniform process for  
15 disseminating to State Medicaid agencies  
16 information under this title impacting con-  
17 tracts between such agencies and such  
18 plans under this subsection; and

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

24           “(B) UNIFIED GRIEVANCES AND APPEALS  
25 PROCESS.—

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

15          “(ii) PROCEDURES.—The procedures  
16          established under clause (i) shall be in-  
17          cluded in the plan contract under para-  
18          graph (3)(D) and shall—

19                 “(I) adopt the provisions for the  
20                 enrollee that are most protective for  
21                 the enrollee and, to the extent feasible  
22                 as determined by the Secretary, are  
23                 compatible with unified timeframes  
24                 and consolidated access to external re-  
25                 view under an integrated process;



1 “(II) take into account dif-  
2 ferences in State plans under title  
3 XIX to the extent necessary;

4 “(III) be easily navigable by an  
5 enrollee; and

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

8 “(iii) ELEMENTS DESCRIBED.—Both  
9 unified appeals and unified grievance pro-  
10 cedures shall include, as applicable, the fol-  
11 lowing elements described in this clause:

12 “(I) Single written notification of  
13 all applicable grievances and appeal  
14 rights under this title and title XIX.  
15 For purposes of this subparagraph,  
16 the Secretary may waive the require-  
17 ments under section 1852(g)(1)(B)  
18 when the specialized MA plan covers  
19 items or services under this part or  
20 under title XIX.

21 “(II) Single pathways for resolu-  
22 tion of any grievance or appeal related  
23 to a particular item or service pro-  
24 vided by specialized MA plans for spe-  
25 cial needs individuals described in

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

3 “(III) Notices written in plain  
4 language and available in a language  
5 and format that is accessible to the  
6 enrollee, including in non-English lan-  
7 guages that are prevalent in the serv-  
8 ice area of the specialized MA plan.

9 “(IV) Unified timeframes for  
10 grievances and appeals processes,  
11 such as an individual’s filing of a  
12 grievance or appeal, a plan’s acknowl-  
13 edgment and resolution of a grievance  
14 or appeal, and notification of decisions  
15 with respect to a grievance or appeal.

16 “(V) Requirements for how the  
17 plan must process, track, and resolve  
18 grievances and appeals, to ensure  
19 beneficiaries are notified on a timely  
20 basis of decisions that are made  
21 throughout the grievance or appeals  
22 process and are able to easily deter-  
23 mine the status of a grievance or ap-  
24 peal.

1           “(iv) CONTINUATION OF BENEFITS  
2           PENDING APPEAL.—The unified procedures  
3           under clause (i) shall, with respect to all  
4           benefits under parts A and B and title  
5           XIX subject to appeal under such proce-  
6           dures, incorporate provisions under current  
7           law and implementing regulations that pro-  
8           vide continuation of benefits pending ap-  
9           peal under this title and title XIX.

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

18           “(D) REQUIREMENTS FOR INTEGRA-  
19           TION.—For 2022 and subsequent years, a spe-  
20           cialized MA plan for special needs individuals  
21           described in subsection (b)(6)(B)(ii) shall meet  
22           one or more of the following requirements, to  
23           the extent permitted under State law, for inte-  
24           gration of benefits under this title and title  
25           XIX:

1           “(i) The specialized MA plan must  
2           meet the requirements of contracting with  
3           the State Medicaid agency described in  
4           paragraph (3)(D) in addition to coordi-  
5           nating long-term services and supports or  
6           behavioral health services, or both, by  
7           meeting an additional minimum set of re-  
8           quirements determined by the Secretary  
9           through the Federal Coordinated Health  
10          Care Office established under section 2018  
11          of the Patient Protection and Affordable  
12          Care Act based on input from stake-  
13          holders, such as notifying the State in a  
14          timely manner of hospitalizations, emer-  
15          gency room visits, and hospital or nursing  
16          home discharges of enrollees, assigning one  
17          primary care provider for each enrollee, or  
18          sharing data that would benefit the coordi-  
19          nation of items and services under this  
20          title and the State plan under title XIX.  
21          Such minimum set of requirements must  
22          be included in the contract of the special-  
23          ized MA plan with the State Medicaid  
24          agency under such paragraph.

1           “(ii) The specialized MA plan must  
2           meet the requirements of a fully integrated  
3           plan       described       in       section  
4           1853(a)(1)(B)(iv)(II) (other than the re-  
5           quirement that the plan have similar aver-  
6           age levels of frailty, as determined by the  
7           Secretary, as the PACE program), or enter  
8           into a capitated contract with the State  
9           Medicaid agency to provide long-term serv-  
10          ices and supports or behavioral health  
11          services, or both.

12           “(iii) In the case where an individual  
13          is enrolled in the specialized MA plan and  
14          a Medicaid managed care organization (as  
15          defined in section 1903(m)(1)(A)) that  
16          provides long term services and supports  
17          or behavioral health services with the same  
18          parent organization, the parent organiza-  
19          tion offering both the specialized MA plan  
20          and the Medicaid managed care plan must  
21          assume clinical and financial responsibility  
22          for benefits provided under this title and  
23          title XIX.”.

24                   (2) CONFORMING AMENDMENT TO RESPON-  
25                   SIBILITIES OF FEDERAL COORDINATED HEALTH

1 CARE OFFICE.—Section 2602(d) of the Patient Pro-  
2 tection and Affordable Care Act (42 U.S.C.  
3 1315b(d)) is amended by adding at the end the fol-  
4 lowing new paragraphs:

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

11 “(7) To be responsible for developing regula-  
12 tions and guidance related to the implementation of  
13 a unified grievance and appeals process as described  
14 in subparagraphs (B) and (C) of section 1859(f)(8)  
15 of the Social Security Act (42 U.S.C. 1395w–  
16 28(f)(8)).”.

17 (c) IMPROVEMENTS TO SEVERE OR DISABLING  
18 CHRONIC CONDITION SNPs.—

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

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

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

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

4 (C) in clause (ii), as redesignated by sub-  
5 paragraph (B), by redesignating clauses (i)  
6 through (iii) as subclauses (I) through (III), re-  
7 spectively, and indenting appropriately; and

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

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

18 “(i) The interdisciplinary team under  
19 subparagraph (A)(ii)(III) includes a team  
20 of providers with demonstrated expertise,  
21 including training in an applicable spe-  
22 cialty, in treating individuals similar to the  
23 targeted population of the plan.

24 “(ii) Requirements developed by the  
25 Secretary to provide face-to-face encoun-

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

4           “(iii) As part of the model of care  
5           under clause (i) of subparagraph (A), the  
6           results of the initial assessment and an-  
7           nual reassessment under clause (ii)(I) of  
8           such subparagraph of each individual en-  
9           rolled in the plan are addressed in the indi-  
10          vidual’s individualized care plan under  
11          clause (ii)(II) of such subparagraph.

12          “(iv) As part of the annual evaluation  
13          and approval of such model of care, the  
14          Secretary shall take into account whether  
15          the plan fulfilled the previous year’s goals  
16          (as required under the model of care).

17          “(v) The Secretary shall establish a  
18          minimum benchmark for each element of  
19          the model of care of a plan. The Secretary  
20          shall only approve a plan’s model of care  
21          under this paragraph if each element of  
22          the model of care meets the minimum  
23          benchmark applicable under the preceding  
24          sentence.”.



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

4                   (A)           IN           GENERAL.—Section  
5           1859(b)(6)(B)(iii) of the Social Security Act  
6           (42 U.S.C. 1395w-28(b)(6)(B)(iii)) is amend-  
7           ed—

8                           (i) by striking “who have” and insert-  
9                           ing “who—

10                                   “(I) before January 1, 2022,  
11                                   have”;

12                                   (ii) in subclause (I), as added by  
13                                   clause (i), by striking the period at the end  
14                                   and inserting “; and”; and

15                                   (iii) by adding at the end the fol-  
16                                   lowing new subclause:

17   “(II) on or after January 1,  
18   2022, have one or more comorbid and  
19   medically complex chronic conditions  
20   that is life threatening or significantly  
21   limits overall health or function, have  
22   a high risk of hospitalization or other  
23   adverse health outcomes, and require  
24   intensive care coordination and that is  
25   listed under subsection (f)(9)(A).”.

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

6 “(9) LIST OF CONDITIONS FOR CLARIFICATION  
 7 OF THE DEFINITION OF A SEVERE OR DISABLING  
 8 CHRONIC CONDITIONS SPECIALIZED NEEDS INDI-  
 9 VIDUAL.—

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

15 “(i) Conditions that meet the defini-  
 16 tion of a severe or disabling chronic condi-  
 17 tion under subsection (b)(6)(B)(iii) on or  
 18 after January 1, 2022.

19 “(ii) Conditions that—

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

1 and would not be needed by the gen-  
 2 eral population of beneficiaries under  
 3 this title; and

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

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

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

22 “(6) QUALITY MEASUREMENT AT THE PLAN  
 23 LEVEL FOR SNPs.—

24 “(A) IN GENERAL.—Subject to subpara-  
 25 graph (B), the Secretary may require reporting

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

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

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

16 “(ii) if quality measures are reported  
17 at the plan level, ensure that MA plans are  
18 not required to provide duplicative infor-  
19 mation; and

20 “(iii) ensure that such reporting does  
21 not interfere with the collection of encoun-  
22 ter data submitted by MA organizations or  
23 the administration of any changes to the  
24 program under this part as a result of the  
25 collection of such data.

1           “(C) APPLICATION.—If the Secretary ap-  
2           plies quality measurement at the plan level  
3           under this paragraph, such quality measure-  
4           ment may include Medicare Health Outcomes  
5           Survey (HOS), Healthcare Effectiveness Data  
6           and Information Set (HEDIS), Consumer As-  
7           sessment of Healthcare Providers and Systems  
8           (CAHPS) measures and quality measures under  
9           part D.

10           “(7) DETERMINATION OF FEASIBILITY OF  
11           QUALITY MEASUREMENT AT THE PLAN LEVEL FOR  
12           ALL MA PLANS.—

13           “(A) DETERMINATION OF FEASIBILITY.—  
14           The Secretary shall determine the feasibility of  
15           requiring reporting of data under section  
16           1852(e) for, and applying under this subsection,  
17           quality measures at the plan level for all MA  
18           plans under this part.

19           “(B) CONSIDERATION OF CHANGE.—After  
20           making a determination under subparagraph  
21           (A), the Secretary shall consider requiring such  
22           reporting and applying such quality measures  
23           at the plan level as described in such subpara-  
24           graph.”.

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

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

13 (A) The characteristics of States in which  
14 the State agency responsible for administering  
15 the State plan under such title XIX has a con-  
16 tract with such a specialized MA plan and that  
17 delivers long term services and supports under  
18 the State plan under such title XIX through a  
19 managed care program, including the require-  
20 ments under such State plan with respect to  
21 long term services and supports.

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

1 (i) A plan described in section  
2 1853(a)(1)(B)(iv)(II) of such Act (42  
3 U.S.C. 1395w-23(a)(1)(B)(iv)(II)).

4 (ii) A plan that meets the require-  
5 ments described in subsection (f)(3)(D) of  
6 such section 1859.

7 (iii) A plan described in clause (ii)  
8 that also meets additional requirements es-  
9 tablished by the State.

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

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

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

19 (ii) Whether all such services and sup-  
20 ports are provided on a capitated basis or  
21 if any of such services and supports are  
22 carved out and provided through fee-for-  
23 service.

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

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

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

11 **TITLE III—EXPANDING**  
 12 **INNOVATION AND TECHNOLOGY**

13 **SEC. 301. ADAPTING BENEFITS TO MEET THE NEEDS OF**  
 14 **CHRONICALLY ILL MEDICARE ADVANTAGE**  
 15 **ENROLLEES.**

16 Section 1859 of the Social Security Act (42 U.S.C.  
 17 1395w–28) is amended by adding at the end the following  
 18 new subsection:

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

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



1           “(2) MODEL DESCRIBED.—The model described  
2           in this paragraph is the testing of a model of Medi-  
3           care Advantage value-based insurance design that  
4           would allow Medicare Advantage plans the option to  
5           propose and design benefit structures that vary ben-  
6           efits, cost-sharing, and supplemental benefits offered  
7           to enrollees with specific chronic diseases proposed  
8           to be carried out in Oregon, Arizona, Texas, Iowa,  
9           Michigan, Indiana, Tennessee, Alabama, Pennsyl-  
10          vania, and Massachusetts.

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

18           “(4) FUNDING.—The Secretary shall allocate  
19          funds made available under section 1115A(f)(1) to  
20          design, implement, and evaluate the model described  
21          in paragraph (2), as expanded under paragraph  
22          (1).”.

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

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

6 (1) in subparagraph (A), by striking “Each”  
 7 and inserting “Subject to subparagraph (D), each”;  
 8 and

9 (2) by adding at the end the following new sub-  
 10 paragraph:

11 “(D) EXPANDING SUPPLEMENTAL BENE-  
 12 FITS TO MEET THE NEEDS OF CHRONICALLY  
 13 ILL ENROLLEES.—

14 “(i) IN GENERAL.—For plan year  
 15 2020 and subsequent plan years, in addi-  
 16 tion to any supplemental health care bene-  
 17 fits otherwise provided under this para-  
 18 graph, an MA plan may provide supple-  
 19 mental benefits described in clause (ii) to  
 20 a chronically ill enrollee (as defined in  
 21 clause (iii)).

22 “(ii) SUPPLEMENTAL BENEFITS DE-  
 23 SCRIBED.—

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

1           spect to a chronically ill enrollee, have  
2           a reasonable expectation of improving  
3           or maintaining the health or overall  
4           function of the chronically ill enrollee  
5           and may not be limited to being pri-  
6           marily health related benefits.

7                   “(II) AUTHORITY TO WAIVE UNI-  
8                   FORMITY REQUIREMENTS.—The Sec-  
9                   retary may, only with respect to sup-  
10                  plemental benefits provided to a  
11                  chronically ill enrollee under this sub-  
12                  paragraph, waive the uniformity re-  
13                  quirement under subsection (d)(1)(A),  
14                  as determined appropriate by the Sec-  
15                  retary.

16                   “(iii) CHRONICALLY ILL ENROLLEE  
17                   DEFINED.—In this subparagraph, the term  
18                   ‘chronically ill enrollee’ means an enrollee  
19                   in an MA plan that the Secretary deter-  
20                   mines—

21                           “(I) has one or more comorbid  
22                           and medically complex chronic condi-  
23                           tions that is life threatening or signifi-  
24                           cantly limits the overall health or  
25                           function of the enrollee;

1                   “(II) has a high risk of hos-  
2                   pitalization or other adverse health  
3                   outcomes; and

4                   “(III) requires intensive care co-  
5                   ordination.”.

6           (b) GAO STUDY AND REPORT.—

7               (1) STUDY.—The Comptroller General of the  
8               United States (in this subsection referred to as the  
9               “Comptroller General”) shall conduct a study on  
10              supplemental benefits provided to enrollees in Medi-  
11              care Advantage plans under part C of title XVIII of  
12              the Social Security Act. Such study shall include an  
13              analysis of the following:

14                   (A) The type of supplemental benefits pro-  
15                   vided to such enrollees, the total number of en-  
16                   rollees receiving each supplemental benefit, and  
17                   whether the supplemental benefit is covered by  
18                   the standard benchmark cost of the benefit or  
19                   with an additional premium.

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

22                   (C) The impact supplemental benefits have  
23                   on—

1 (i) indicators of the quality of care re-  
 2 ceived by such enrollees, including overall  
 3 health and function of the enrollees;

4 (ii) the utilization of items and serv-  
 5 ices for which benefits are available under  
 6 the original Medicare fee-for-service pro-  
 7 gram option under parts A and B of such  
 8 title XVIII by such enrollees; and

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

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

20 **SEC. 303. INCREASING CONVENIENCE FOR MEDICARE AD-**  
 21 **VANTAGE ENROLLEES THROUGH TELE-**  
 22 **HEALTH.**

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

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

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

5           “(m) PROVISION OF ADDITIONAL TELEHEALTH  
6 BENEFITS.—

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

12          “(2) ADDITIONAL TELEHEALTH BENEFITS DE-  
13          FINED.—

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

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

18                                 “(I) for which benefits are avail-  
19                                 able under part B, including services  
20                                 for which payment is not made under  
21                                 section 1834(m) due to the conditions  
22                                 for payment under such section; and

23                                 “(II) that are identified as clini-  
24                                 cally appropriate to furnish using elec-  
25                                 tronic information and telecommuni-

1 cations technology when a physician  
2 (as defined in section 1861(r)) or  
3 practitioner (described in section  
4 1842(b)(18)(C)) providing the service  
5 is not at the same location as the plan  
6 enrollee.

7 “(ii) EXCLUSION OF CAPITAL AND IN-  
8 FRASTRUCTURE COSTS AND INVEST-  
9 MENTS.—The term ‘additional telehealth  
10 benefits’ does not include capital and infra-  
11 structure costs and investments relating to  
12 such benefits.

13 “(B) PUBLIC COMMENT.—Not later than  
14 November 30, 2018, the Secretary shall solicit  
15 comments on what types of telehealth services  
16 currently offered to enrollees under this part  
17 through supplemental health care benefits  
18 should be considered to meet the definition of  
19 additional telehealth benefits under this para-  
20 graph.

21 “(3) REQUIREMENTS FOR ADDITIONAL TELE-  
22 HEALTH BENEFITS.—The Secretary shall specify re-  
23 quirements for the provision or furnishing of addi-  
24 tional telehealth benefits, including with respect to  
25 the following:

1           “(A) Physician or practitioner licensure  
2           and other requirements such as specific train-  
3           ing.

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

7           “(C) Such other areas as determined by  
8           the Secretary.

9           “(4) ENROLLEE CHOICE.—If an MA plan pro-  
10          vides a service as an additional telehealth benefit (as  
11          defined in paragraph (2)), an individual enrollee  
12          shall have discretion as to whether to receive such  
13          service as an additional telehealth benefit.

14          “(5) CONSTRUCTION REGARDING NETWORK AC-  
15          CESS ADEQUACY.—Provision of additional telehealth  
16          benefits under this subsection shall not be construed  
17          as making such benefits available and accessible for  
18          purposes of compliance with subsection (d).

19          “(6) TREATMENT UNDER MA.—For purposes of  
20          this subsection and section 1854, additional tele-  
21          health benefits shall be treated as if they were bene-  
22          fits under the original Medicare fee-for-service pro-  
23          gram option.

24          “(7) CONSTRUCTION.—Nothing in this sub-  
25          section shall be construed as affecting the require-



1       ment under subsection (a)(1) that MA plans provide  
 2       enrollees with items and services (other than hospice  
 3       care) for which benefits are available under parts A  
 4       and B, including benefits available under section  
 5       1834(m).”.

6       (b) CLARIFICATION REGARDING INCLUSION IN BID  
 7 AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Se-  
 8 curity Act (42 U.S.C. 1395w-24(a)(6)(A)(ii)(I)) is  
 9 amended by inserting “, including, for plan year 2020 and  
 10 subsequent plan years, the provision of additional tele-  
 11 health benefits as described in section 1852(m)” before  
 12 the semicolon at the end.

13 **SEC. 304. PROVIDING ACCOUNTABLE CARE ORGANIZA-**  
 14                   **TIONS THE ABILITY TO EXPAND THE USE OF**  
 15                   **TELEHEALTH.**

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

19       “(1) PROVIDING ACOs THE ABILITY TO EXPAND  
 20 THE USE OF TELEHEALTH SERVICES.—

21               “(1) IN GENERAL.—In the case of telehealth  
 22 services for which payment would otherwise be made  
 23 under this title furnished on or after January 1,  
 24 2020, for purposes of this subsection only, the fol-  
 25 lowing shall apply with respect to such services fur-

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

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

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

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

17 “(A) APPLICABLE ACO.—The term ‘appli-  
18 cable ACO’ means an ACO participating in a  
19 model tested or expanded under section 1115A  
20 or under this section—

21 “(i) that operates under a two-sided  
22 model—

23 “(I) described in section  
24 425.600(a) of title 42, Code of Fed-  
25 eral Regulations; or

1                   “(II) tested or expanded under  
2                   section 1115A; and

3                   “(ii) for which Medicare fee-for-serv-  
4                   ice beneficiaries are assigned to the ACO  
5                   using a prospective assignment method, as  
6                   determined appropriate by the Secretary.

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

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

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

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

24                  (b) STUDY AND REPORT.—

25                  (1) STUDY.—

1 (A) IN GENERAL.—The Secretary of  
2 Health and Human Services (in this subsection  
3 referred to as the “Secretary”) shall conduct a  
4 study on the implementation of section 1899(l)  
5 of the Social Security Act, as added by sub-  
6 section (a). Such study shall include an analysis  
7 of the utilization of, and expenditures for, tele-  
8 health services under such section.

9 (B) COLLECTION OF DATA.—The Sec-  
10 retary may collect such data as the Secretary  
11 determines necessary to carry out the study  
12 under this paragraph.

13 (2) REPORT.—Not later than January 1, 2026,  
14 the Secretary shall submit to Congress a report con-  
15 taining the results of the study conducted under  
16 paragraph (1), together with recommendations for  
17 such legislation and administrative action as the  
18 Secretary determines appropriate.

19 **SEC. 305. EXPANDING THE USE OF TELEHEALTH FOR INDI-**  
20 **VIDUALS WITH STROKE.**

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

1           “(6) TREATMENT OF STROKE TELEHEALTH  
2 SERVICES.—

3           “(A) NON-APPLICATION OF ORIGINATING  
4 SITE REQUIREMENTS.—The requirements de-  
5 scribed in paragraph (4)(C) shall not apply with  
6 respect to telehealth services furnished on or  
7 after January 1, 2019, for purposes of evalua-  
8 tion of an acute stroke, as determined by the  
9 Secretary.

10           “(B) NO ORIGINATING SITE FACILITY  
11 FEE.—The Secretary shall not pay an origi-  
12 nating site facility fee (as described in para-  
13 graph (2)(B)) with respect to such telehealth  
14 services.”.

15           **TITLE IV—IDENTIFYING THE**  
16 **CHRONICALLY ILL POPULATION**

17 **SEC. 401. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO**  
18 **BE PART OF AN ACCOUNTABLE CARE ORGA-**  
19 **NIZATION.**

20           Section 1899(c) of the Social Security Act (42 U.S.C.  
21 1395jjj(c)) is amended—

22           (1) by redesignating paragraphs (1) and (2) as  
23 subparagraphs (A) and (B), respectively, and indent-  
24 ing appropriately;

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

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

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

7           “(2) PROVIDING FLEXIBILITY.—

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

20           “(B) ASSIGNMENT BASED ON VOLUNTARY  
21           IDENTIFICATION BY MEDICARE FEE-FOR-SERV-  
22           ICE BENEFICIARIES.—

23           “(i) IN GENERAL.—For performance  
24           year 2019 and each subsequent perform-  
25           ance year, if a system is available for elec-

1 tronic designation, the Secretary shall per-  
2 mit a Medicare fee-for-service beneficiary  
3 to voluntarily identify an ACO professional  
4 as the primary care provider of the bene-  
5 ficiary for purposes of assigning such bene-  
6 ficiary to an ACO, as determined by the  
7 Secretary.

8 “(ii) NOTIFICATION PROCESS.—The  
9 Secretary shall establish a process under  
10 which a Medicare fee-for-service bene-  
11 ficiary is—

12 “(I) notified of their ability to  
13 make an identification described in  
14 clause (i); and

15 “(II) informed of the process by  
16 which they may make and change  
17 such identification.

18 “(iii) SUPERSEDING CLAIMS-BASED  
19 ASSIGNMENT.—A voluntary identification  
20 by a Medicare fee-for-service beneficiary  
21 under this subparagraph shall supersede  
22 any claims-based assignment otherwise de-  
23 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 his representative.

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

20 (5) Potential options for ensuring that applica-  
21 ble providers are notified of a patient's existing lon-  
22 gitudinal care plan and that applicable providers  
23 consider that plan in making their treatment deci-  
24 sions, and what the challenges might be in imple-  
25 menting such options.

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

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

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

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

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

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

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

23                   (B) the documentation of the care plan;

24                   (C) services furnished to the beneficiary;

25           and

1 (D) outcomes of treatment.

2 (8) Stakeholder's views on—

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

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

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

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

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

25 (c) DEFINITIONS.—In this section:

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

8                   (A) furnishes longitudinal comprehensive  
9                   care planning services through an interdis-  
10                  ciplinary team; and

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

13           (2) COMPTROLLER GENERAL.—The term  
14           “Comptroller General” means the Comptroller Gen-  
15           eral of the United States.

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

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

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

22                   (C) may include other direct care per-  
23                   sonnel.

24           (4) LONGITUDINAL COMPREHENSIVE CARE  
25           PLANNING SERVICES.—The term “longitudinal com-

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

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

16 **TITLE VI—OTHER POLICIES TO**  
 17 **IMPROVE CARE FOR THE**  
 18 **CHRONICALLY ILL**

19 **SEC. 601. GAO STUDY AND REPORT ON IMPROVING MEDI-**  
 20 **CATION SYNCHRONIZATION.**

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

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

7           (1) The extent to which pharmacies have adopt-  
8           ed such programs.

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

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

18          (4) What is known about how such programs  
19          affect patient medication adherence and overall pa-  
20          tient health outcomes and health outcomes, includ-  
21          ing if adherence and outcomes vary by patient sub-  
22          populations, such as disease state and socioeconomic  
23          status.

24          (5) What is known about overall patient satis-  
25          faction with such programs and satisfaction with

1 such programs, including within patient subpopula-  
2 tions, such as disease state and socioeconomic sta-  
3 tus.

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

6 (7) Barriers to the use of medication synchroni-  
7 zation programs by Medicare prescription drug  
8 plans.

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

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

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

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

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

7 (2) The utilization of obesity drugs.

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

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

16 (5) Physician considerations and attitudes re-  
17 lated to prescribing obesity drugs.

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

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



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

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

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

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

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