Description of the Chairman's Mark

The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017

Scheduled for Markup
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Title I—Receiving High-Quality Care in the Home

Section 101:

Current Law

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) created the Independence at Home (IAH) demonstration under the Medicare program (Section 1866E of the Social Security Act (SSA), 42 U.S.C. 1395cc–5) to test a payment incentive and service delivery model that uses physician- and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to certain chronically ill Medicare beneficiaries. Qualifying IAH medical practices are physician or nurse practitioner-led legal entities that may also include physician assistants, pharmacists, and other health and social services staff. Such practice staff are to have experience providing home-based primary care services to applicable beneficiaries. Practice staff are required to make in-home visits and to be available 24 hours per day, 7 days per week to implement care plans tailored to the individual beneficiary's chronic conditions. Qualifying medical practices are eligible to receive incentive payments, subject to meeting an expenditure target and performance standards on quality measures. The Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) initially selected a total of 15 individual practices, later supplemented by three consortia, to participate in the IAH demonstration. The demonstration began on June 1, 2012, and is to end on September 30, 2017.

Proposed Provision

The Chairman's Mark makes three modifications that would extend and expand the IAH demonstration: (1) the maximum length of an agreement with an IAH medical practice under the demonstration program would increase from 5 to 7 years, effectively extending the demonstration by 2 years; (2) the limit on the total number of beneficiaries across all selected IAH medical practices participating in the demonstration would be increased from 10,000 to 15,000; and (3) an IAH medical practice would have three years (instead of two under current law) to demonstrate savings and receive incentive payments before it is terminated from the IAH demonstration.

Section 102: Expanding Access to Home Dialysis Therapy

Current Law

Medicare regulations require that beneficiaries with End Stage Renal Disease (ESRD) undergoing home-based dialysis treatment receive monthly face-to-face assessments from a qualified physician or practitioner. ESRD beneficiaries may receive the required monthly assessment via approved telehealth services only if (1) the telehealth assessment occurs in a Medicare-authorized originating site (such as a physician's office or hospital-based dialysis facility), and (2) the site is located in a rural Health Professional Shortage Area (HPSA) or a county not included in a Metropolitan Statistical Area (MSA).

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. The services must be either (1) remote patient and physician or practitioner face-to-face services delivered via a telecommunciations system, or (2) non face-to-face services conducted 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).The

originating site must be in a rural HPSA, a county not included in a MSA, or from an entity that participates in a Federal telemedicine demonstration project. Qualifying originating sites include an office of a physician or practitioner, a critical access hospital (CAH), a rural health clinic, a Federally qualified health center, a hospital, a hospital- or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center.

Proposed Provision

The Chairman's Mark would allow Medicare ESRD beneficiaries undergoing home dialysis to receive required monthly clinical assessments by physicians or practitioners using telehealth services, beginning on January 1, 2019, so long as the individual receives a face-to-face clinical assessment, without the use of telehealth, at least once every three consecutive months. The section would expand the current list of allowable originating sites for a telehealth assessment to include freestanding renal dialysis facilities and beneficiary homes. The provision would also eliminate geographic limits that now require an originating site to be located in a HPSA or a county not included in an MSA. A separate facility fee would not be provided if the originating site is the beneficiary's home.

Title II—Advancing Team-Based Care

Section 201. Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) established a new type of Medicare Advantage (MA) coordinated care plan to focus on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized (I-SNPs), (2) dually eligible—low-income Medicare beneficiaries who also are eligible for Medicaid—(D-SNPs), and/or (3) individuals with severe or disabling chronic conditions (C-SNPs).

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including: state licensure as a risk-bearing entity, MA reporting requirements that are applicable depending on plan size, and Part D prescription drug benefit requirements. SNPs prepare and submit bids to CMS like other MA plans and are paid using the same methodology as for other MA plans, based on the plan's enrollment after risk adjusting payments for beneficiary characteristics.

Among other changes, the Medicare Improvements for Patients and Providers Act of 2010 (MIPPA, P.L. 110-275) required that all SNPs have evidenced-based models of care (MOC). MIPPA required Medicare advantage organizations offering SNPs to tailor separate MOCs to meet the special needs of SNP target populations. MOCs must have goals and objectives for the targeted population, a specialized provider network, use nationally-recognized clinical practice guidelines, conduct health risk assessments to identify the special needs of beneficiaries, and add services for the most vulnerable beneficiaries including those beneficiaries who are frail, disabled, or near the end-of-life.

The ACA extended SNP authority through December 31, 2013. Since ACA enactment, SNPs have been extended a number of times, most recently through December 31, 2018 by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10). ACA also expanded the D-SNP category by authorizing fully-integrated dual-eligible SNPs (FIDE-SNPs). FIDE-SNPs are a subset of D-SNPs that meet additional requirements such as fully integrating Medicare and Medicaid benefits under a single managed care entity; having an approved risk-based Medicaid contract; coordinating care, including long-term care services; using a specialty care network for high-risk beneficiaries; and employing approved policies and procedures to coordinate or integrate enrollment, member materials, communications,

grievances and appeals, and quality improvement activities. Other SNP-related ACA provisions made the following changes:

- Required all SNPs to comply with an approval process based on CMS standards and executed by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012.
- Authorized CMS to make a frailty adjustment payment to FIDE-SNPs.
- Required CMS to implement new quality-based payment procedures for all MA plans by 2012.
- Required the Secretary to establish the Federal Office of (Medicare and Medicaid) Coordinated Health Care (MMCO) within CMS to facilitate Medicare and Medicaid coordination, dual eligible beneficiary care, and other activities.

CMS's monthly enrollment data shows that SNP enrollment has increased from 670,500, in May 2007 to approximately 2.36 million in April 2017. SNP enrollment is concentrated in D-SNPs, which account for approximately 83% of the total 2.36 million April 2017 enrollment (D-SNPs, 1.96 million, C-SNPs, 335,000, and I-SNPs, 63,500). Moreover, SNP enrollment also is concentrated geographically, with 9 states and Puerto Rico accounting for approximately 79% of January 2015 enrollment. In April 2015, there were 37 FIDE-SNPs operating in 9 states with total enrollment of approximately 107,800. Approximately 65% of that January 2015 FIDE-SNP enrollment (about 70,000) was in Massachusetts and Minnesota.

Proposed Provision

The Chairman's Mark would permanently authorize SNPs if certain additional policy requirements are met. Rather than current authority expiring on December 31, 2018, SNPs could continue to enroll qualifying Medicare beneficiaries so long as they adopt the requirements outlined in the bill into D-SNPs, C-SNPs, and I-SNPs, and new SNPs could be established.

The Secretary of HHS ("the Secretary") would be required to increase D-SNP integration of Medicare and Medicaid by designating MMCO as the dedicated CMS contact point to assist states in addressing D-SNP Medicare-Medicaid misalignments. In this role, MMCO would be required to establish a uniform process for disseminating Medicare contract information to state Medicaid agencies as well as to D-SNPs and to establish basic resources for states interested in exploring D-SNPs as a platform for integrating Medicare-Medicaid services for dual eligible beneficiaries.

The Secretary, to the extent feasible, would be required to establish procedures by April 1, 2020 that would unify the Medicare and Medicaid fee-for-service (FFS) and managed care grievance and appeals procedures applicable to D-SNPs. In establishing unified Medicare-Medicaid grievance and appeals procedures, the Secretary would be required to solicit comments from states, plans, beneficiary representatives, and other relevant stakeholders. In addition, the Secretary would be required to ensure that unified grievance and appeals procedures would be included in D-SNP contracts and would:

- adopt current law provisions that would be most protective of D-SNP enrollees and also would be most compatible with Medicare and Medicaid unified timeframes and consolidated access to external review under an integrated process, as determined by the Secretary;
- take into account Medicaid state plan differences;
- be easily navigable by D-SNP enrollees; and
- include, if applicable, the following elements:
    - a single written notification of all applicable Medicare and Medicaid grievance and appeal rights (the Secretary would be authorized to waive certain notification requirements when an item or service was covered by Medicare or Medicaid);

- single pathway for resolution or appeal related to a particular item or service covered by a D-SNP or Medicaid;
- procedures written in plain language and available in a language and format that is accessible to enrollees, including non-English languages prevalent in the D-SNP service area;
- unified Medicare and Medicaid timeframes for grievance and appeal processes such as the enrollee's filing of appeals or grievances, plan acknowledgement, resolution of a grievance or appeal, and notification of appeal or grievance decisions.
- requirements for how D-SNP plans process, track, and resolve appeals and grievances to ensure timely beneficiary notification of decisions made throughout the appeal and grievance process and for which the appeal and grievance status would be easy to determine.

The Chairman's Mark also would require that the unified grievance and appeals procedures for Medicare and Medicaid services established by the Secretary incorporate provisions under current law and further require the implementation of regulations that would continue enrollee benefits pending a grievance or appeal process. Beginning January 1, 2021 and for subsequent years, D-SNP plan contracts with state Medicaid agencies would be required to use the new unified Medicare-Medicaid grievance and appeals procedures.

D-SNP contracts with state Medicaid agencies in effect on or after January 1, 2021, would be required to meet one or more of the following requirements for integration of Medicare and Medicaid benefits, to the extent permitted under state law:

- Enter into a contract with a state Medicaid agency and coordinate long-term services and supports (LTSS), behavioral health services, or both by meeting an additional minimum set of requirements determined by the Secretary through the MMCO and based on input from stakeholders. These requirements could include the following and would have to be included in the D-SNP contract with the state Medicaid agency:
  - D-SNP notification for the state in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees;
  - assigning one primary care provider for each enrollee; or
  - sharing data that would benefit the coordination of Medicare and Medicaid items and services.
- Satisfy the requirements of a FIDE-SNP, except the requirement that the D-SNP have similar average levels of frailty as the Program for All-inclusive Care for the Elderly (PACE) or enter into a capitated contract with the state Medicaid agency to provide LTSS, behavioral health, or both LTSS and behavioral health.
- The parent organization must assume clinical and financial responsibility for the Medicare and Medicaid benefits provided to individuals who are enrolled in a D-SNP and a Medicaid managed care organization that provides LTSS or behavioral health services, with the same parent organization.

MMCO would be responsible for the following:

- the designated contact for state Medicaid agencies in the integration of D-SNPs; and
- the development of regulations and guidance to implement a unified grievance and appeals process.

Effective for SNP contracts beginning January 1, 2020 and in subsequent years, the Secretary would add the following C-SNP care management plan requirements:

- C-SNP interdisciplinary provider teams would include providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the C-SNP targeted population;
- enrolled individuals would receive face-to-face encounters with the C-SNP at least annually;
- the MOC would include the results of the initial assessment as well as each annual reassessment, and the results of those assessments would be addressed in the enrollee's individualized care plan;
- the annual MOC evaluation and approval would take into account whether or not the plan fulfilled the goals identified in the previous year's MOC goals; and
- a C-SNPs MOC would only be approved if the C-SNP achieved established minimum benchmarks for each MOC element.

Effective for C-SNP contracts beginning on or after January 1, 2022, Section 201 would revise the definition of individuals eligible for C-SNPs to include Medicare beneficiaries who (i) have one or more comorbid and medically complex chronic conditions that is life threatening or that significantly limits overall health or function, (ii) have a high-risk of hospitalization or other adverse health outcome, (iii) require intensive care coordination, and (iv) is identified on the list of conditions approved by the panel of clinical advisors described below. The Secretary would be required to convene a clinical advisor panel to identify C-SNP conditions by December 31, 2020, and every five years thereafter. The C-SNP condition clinical advisory panel would establish and update the list of severe or disabling chronic conditions that met the following criteria:

- conditions that require prescription drugs, providers, and models of care that are unique to the specific population of enrollees of a C-SNP on or after December 1, 2020, with similar services not needed by the general population of Medicare beneficiaries; and
- Conditions that have a low prevalence in the general population of Medicare beneficiaries or a disproportionally high per-beneficiary cost.

In establishing and updating the C-SNP condition list, the clinical advisory panel would be required to take into account the availability of varied benefits, cost-sharing, and supplemental benefits described in Section 301 of the Chairman's Mark.

The Secretary could require quality data reporting and apply those ratings to SNPs at the plan level instead of the contract level. Prior to applying quality measurement at the plan level, the Secretary would be required to:

- consider the minimum number of SNP enrollees to determine if a statistically significant or valid measurement of quality at the plan level would be possible;
- ensure that if plan level quality measures are reported, that MA plans would not be required to report duplicative information; and
- ensure that plan level quality reporting would not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program as a result of the plan level data collection.

If the Secretary applies quality measurement at the plan level, the specific quality measurement could include measures from the Medicare Health Outcomes Survey (HOS), the Healthcare Effectiveness Data Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) as well as quality measures under Medicare Part D. The Secretary would determine the feasibility of requiring all MA plans to report quality measures at the plan level and would consider applying this requirement following this assessment.

The Comptroller General would conduct a study on state-level integration between SNPs and Medicaid that would include analyses of the following:

- the characteristics of states where the state Medicaid agency has a contract with D-SNPs that delivers LTSS through a managed care program, including state plan LTSS requirements;
- the various types of SNPs, which may include the following: 1) a FIDE-SNP; 2) a D-SNP that has a contract with a state Medicaid agency, which may include LTSS; and 3) a D-SNP that has a contract with a state Medicaid agency that meets additional requirements established by the state;
- the characteristics of individuals enrolled in D-SNPs;
- as practicable, the following with respect to state programs for the delivery of LTSS through Medicaid managed care plans:
    - the populations eligible to receive LTSS, and
    - the SNPs where LTSS are provided on a capitated basis or, where LTSS are carved out and provided through FFS Medicaid, if any; and
    - the integration arrangements of D-SNPs offered across states and how their availability and variation affect expenditures, service delivery options, access to community care, and the utilization of care.

The Comptroller General would submit the report to Congress within two years of the date of enactment, including recommendations for legislation and administrative action as determined appropriate.

Title III—Expanding Innovation and Technology

Section 301. Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Current Law

Under Medicare Advantage, private health plans are paid a per–person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiareis who enroll, regardless of how many or how 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. CMMI is currently testing a model to allow greater flexibility for an MA plan to meet the needs of chronically ill enrollees. Under the model, plans are allowed to propose and design offerings that vary the benefits, cost-sharing, and supplemental benefits offered to enrollees with specific conditions. The first year of the model, which began January 1, 2017, is being conducted in seven states. The second year of the model, beginning January 1, 2018, will add three additional states.

Proposed Provision

The Chairman's Mark 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. The section would delay until January 1, 2022 the authority for the Secretary to terminate or modify the model. The model would be permitted to continue after January 1, 2022 if it can be shown that the model is expected to (a) improve quality of care without increasing spending, (b) reduce spending without reducing quality of care, or (c)

improve the quality of care and reduce spendig. Funding for the desgn, implementation, and evaluation of the expanded model is to be allocated by the Secretary from appropriations applied to CMMI.

Section 302. Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Current Law

All 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 beneficiary cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollees may choose whether 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 supplemntal 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 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).

Proposed Provision

The Chairman's Mark 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 defined as those that 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. For purposes of this section, a chroniclly ill enrollee would be defined as those who have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit the overall health or functioning of the enrollee, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination. The section would allow an MA plan the flexibility to provide targeted supplemental benefits to specific chronically ill enrollees. The Chairman's Mark would require the Comptroller General to conduct a study on the supplemental benefits provided by MA plans. The study would be required to include specified analyses on topics including the availability, utilization, and cost of the supplemental benefits, the impact on quality, health, utilization of other services, and the savings resulting from the supplemental benefits. The study would include recommendations for legislative and administrative actions as the Comptroller sees fit. The Comptroller General would submit the report to Congress not later than five years after the date of enactment.

Section 303. Increasing Convenience for Medicare Advantage Enrollees Through Telehealth

Current Law

MA plans are paid a per person monthly amount. The Secretary determines a plan's payment by comparing its bid to a benchmark. A bid is the plan's estimated cost of providing Medicare-covered services (excluding hospice but including the cost of medical services, administration, and profit). In general, the Secretary has the authority to review and negotiate plan bids to ensure that they reflect revenue requirements. A benchmark is the maximum amount the federal government will pay for providing those services in the plan's service area. If a plan's bid is less than the benchmark, the plan's payment equals its bid plus a rebate. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Medicare Part B or Part D premiums, or some combination of these options.

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) plans may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management (MTM). However, MA plans that want to provide telemedicine or other technologies that they believe promote efficiences beyond what is covered in the traditional Medicare program must receive approval to provide them as a supplemental benefit, and must use their rebate dollars to pay for those services.

Proposed Provision

The Chairman's Mark would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive paymet under Part B beginning in 2020. The Secretary would be required, no later than November 30, 2018, to solicit comments on what types of telehealth services that are currently offered as supplemental benefits should be considered to be additional telehealth benefits, and the requirements for the provision or furnishing of those benefits (such as licensure, training, and coordination). The costs of telehealth benefits included in the bid would not include capital and infrastructure related costs or investments. The use of these technologies would not be a substitute for meeting network adequacy requirements, and the beneficiary would have the ability to decide whether or not be receive the services via telehealth. This section would not affect the requirement that MA plans must provide enrolees with all benefits under Parts A and B of Medicare (except hospice).

Section 304: Providing Accountable Care Organizations the Ability to Expand the Use of Telehealth

Current Law

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. In order to be eligible for Medicare payment, telehealth services must be provided at a qualifying site in a rural health professional shortage area (HPSA), a county not included in a Metropolitan Statistical Area (MSA), or from an entity that participates in a Federal telemedicine demonstration project. Qualifying "originating sites" include an office of a physician or practitioner, a critical access hospital (CAH), a rural health clinic, a Federally qualified health center, a hospital, a hospital- or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center.

Medicare accountable care organizations (ACOs) were authorized in the Affordable Care Act, and initial models included the fee–for–service based Medicare Shared Savings Program (MSSP) and the Pioneer ACOs, which received population–based payments or capitation. While current laws and rules do not preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies to their patients, ACOs do not receive additional Medicare payment for furnishing those services and technologies.

In December 2016, CMS announced the Next Generation ACO Model, with modified benchmarking methods, additional payment mechanisms (including capitation), and various "benefit enhancements," including better access to (and payment consideration for) telehealth services.

Proposed Provision

The Chairman's Mark would expand the ability of certain MSSP ACOs and ACOs tested or expanded through the CMS Center for Medicare and Medicaid Innovation (CMMI) to furnish and receive payments for telehealth services by applying the Next Generation ACO telehealth waiver, beginning January 1, 2020. As a result, the Chairman's Mark 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. In order for an ACO to be eligible to receive these telehealth payments, it must also be an ACO to which beneficiaries are prospectively assigned and it must accept two–sided risk for both bonuses rewarded for realized savings as well as penalties associated with some cost overages. When the home of a beneficiary receiving the services is the originating site, then no facility fee would be paid. There would also be no payment for services that are inappropriate for the home setting, such as those typically furnished to hospital inpatients.

No later than January 1, 2026, the Secretary would submit a report to Congress on the implementation of this section that would include an analysis of the utilization of, and expenditures for, telehealth services provided by ACOs, together with recommendations for legislation and administration action as the Secretary determines appropriate.

Section 305: Expanding The Use Of Telehealth For Individuals With Stroke

Current Law

Patients who have stroke symptoms or have had a stroke may receive care in a number of sites and across different providers. In addition to physician services, stroke patients may require care at an acute care hospital (inpatient and/or outpatient), inpatient rehabilitation facility (IRF), or skilled nursing facility (SNF). For covered Medicare services provided to stroke patients, physicians are paid according to the Medicare Physician Fee Schedule (MPFS), hospitals according to the inpatient prospective payment system (IPPS) or outpatient prospective payment system (OPPS), IRFs under the IRF PPS, and SNFs under the SNF PPS. Under current law, telehealth restrictions (due to SSA Section 1834(m)) apply to all such services. In the case of telehealth services for the evaluation of acute stroke, the originating site hospital must be in a rural health professional shortage area (HPSA), a county not included in a Metropolitan Statistical Area (MSA), or an entity that participates in a Federal telemedicine demonstration project.

Proposed Provision

The Chairman's Mark would eliminate the originating site geographic restrictions for telehealth services furnished for the purpose of evaluating an acute stroke as (determined by the Secretary), beginning January 1, 2021. Removing this restriction would provide payment to the distant consulting physician regardless of the originating site hospital's location. In the case where a hospital is newly eligible to serve as an originating site, that hospital would not receive an originating site telehealth facility fee.

Title IV—Identifying the Chronically Ill Population

Section 401: Providing Flexibility For Beneficiaries To Be Part Of An Accountable Care Organization

Current Law

Initially, Medicare fee-for-service beneficiaries were assigned to an ACO based on their utilization of primary care services provided by a physician who participated in an ACO. Under these original models, beneficiaries 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 are assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Primary care physicians are defined as those with one of four specialty designations: internal medicine, general practice, family practice, and geriatric medicine or for services furnished in a federally qualified health center (FQHC) or rural health clinic (RHC), a physician included in the attestation provided by the ACO as part of its application. 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 and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO. Medicare beneficiaries enrolled in a Medicare Advantage plan cannot be enrolled in an ACO.

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 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. The initial implementation of MSSP ACOs (Tracks 1 and 2) retrospectively assigned beneficiaries to ACOs. 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. The introduction of Track 3 MSSP ACOs allows prospective beneficiary assignment (along with other changes in the assumption of risk and rewards). Prospective assignment allows ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to conect 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.

Proposed Provision

The Chairman's Mark would allow MSSP ACOs the choice of prospective assignment, beginning with agreements entered into or renewed on or after January 1, 2020. In addition, beneficiaries would be able to voluntarily identify an ACO professional as their primary care provider and be assigned to that ACO beginning with the 2018 performance year. The Secretary would establish a process to notify Medicare beneficiaries of their ability to make such a voluntary identification, and how to make or change this designation. The beneficiary's voluntary identification would supersede any other claims-based assignment to an ACO.

Title V—Empowering Individuals and Caregivers in Care Delivery

Section 501: Eliminating Barriers to Care Coordination Under Accountable Care Organizations

Current Law

ACOs were conceived as collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others around the ability to receive shared-saving bonuses or losses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients. Beneficiaries who are assigned to or voluntarily elect to be identified with an ACO continue to have standard Medicare Part A and B cost-sharing responsibilities, including deductibles and coinsurance payments.

Proposed Provision

The Chairman's Mark would authorize the Secretary to create an ACO Beneficiary Incentive Program, intended to encourage beneficiaries to obtain medically necessary primary care services by permitting incentive payments to beneficiaries. The program would be established no earlier than January 1, 2019 and no later than January 1, 2020. The Secretary could terminate the program at any time.

Current and future ACOs that have agreed to two-sided risk/reward models could apply to establish a program that would provide incentive payments to beneficiaries assigned to the ACO who receive primary care services from (i) a physician who has a primary care specialty designation, or (ii) a physician assistant, nurse practitioner, or clinical nurse specialist participating in the ACO, or (iii) a Federally qualified health center or rural health clinic. The program would continue for at least one year. The incentive payment could be up to $20, with the maximum amount to be updated annually by the percentage increase in the consumer price index. The incentive payment would be made regardless of whether or not the beneficiary is enrolled in a Medicare supplemental policy (Medigap), a Medicaid plan or waiver, or any other health insurance policy or health benefit plan, and would be made for each qualifying (primary care) service. The payment would be made no later than 30 days after the service is furnished.

The Secretary would not make any payments to the ACOs for the costs associated with the implementation of the ACO Beneficiary Incentive Program. The incentive payments would be disregarded for purposes of calculating ACO benchmarks, estimated average per capita Medicare expenditures, and shared savings. ACOs would be required to report to CMS the amount and frequency of the incentive payments made and the number of beneficiaries receiving the payments.

Incentive payments made under an ACO Beneficiary Incentive Program would not be considered income or resources or otherwise be taken into account for purposes of determining eligibility for benefits or assistance under any Federal program or under any State or local program financed in whole or in part with Federal funds, or for any Federal or State tax laws.

The Secretary would conduct an evaluation of the ACO Beneficiary Incentive Program that would include an analysis of the impact of the implementation of the program on Medicare expenditures and beneficiary health outcomes. A report would be due to Congress no later than October 1, 2023, containing the results of the evaluation together with recommendations for such legislation and administrative action as the Secretary were to determine appropriate.

Section 502: GAO study and report on longitudinal comprehensive care planning services under Medicare part B

Current Law

No current law.

Proposed Provision

The Chairman's Mark would require the Comptroller General to conduct a study on the establishment of a payment code, under Medicare Part B, for a beneficiary visit with an applicable provider for longitudinal comprehensive care planning services. In this section the term, "longitudinal comprehensive care planning services" would mean "a voluntary shared decision-making process that is furnished by an applicable provider through an interdisciplinary team and includes a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness." The term "applicable provider" would mean a hospice program or other provider of services (e.g., hospital, skilled nursing facility, home health agency), that furnishes longitudinal comprehensive care planning services through an interdisciplinary team, and meets such other requirements as the Secretary might determine to be appropriate. The term "interdisciplinary team" would mean a group that includes at least one physician, one registered professional nurse, and one social worker, and could include a chaplain, minister, or other clergy, and other direct care personnel. The purpose of such services would be "to discuss a longitudinal care plan that addresses the progression of the disease, treatment options, the goals, values, and preferences of the beneficiary, and the availability of other resources and social supports that may reduce the beneficiary's health risks and promote self-management and shared decision making."

The study would include analyses of a number of issues related to long-term comprehensive care planning, including the availability, use, and efficiency of existing services, and an examination of the barriers to and quality metrics for such care. The report would include many stakeholder views and concerns. The Comptroller General would submit the report to Congress no later than 18 months after the date of the enactment, together with recommendations for such legislation and administrative action as the Comptroller General sees fit.

Title VI—Other Policies to Improve Care for the Chronically Ill

Section 601: Government Accountability Office (GAO) Study and Report on Improving Medication Synchronization

Current Law

Individuals with chronic conditions are often prescribed multiple prescriptions by different clinicians. Because many prescriptions are for a standard period of time (i.e., 30 days) but may be prescribed at separate points during a course of treatment, a patient might have to fill a number of prescriptions at different times each month. There is a move toward prescription synchronization to enable patients to fill multiple prescriptions from various providers at the same time each month in an effort to improve prescription adherence. In 2012, CMS announced a regulatory change making it easier for Medicare Part D enrollees and their prescribers to synchronize prescriptions (42 CFR §423.153(b)(4)). Under the rule, which took effect at the beginning of 2014, Part D plans must apply a pro-rated daily cost-sharing rate to prescriptions for less than a 30-days' supply of a drug dispensed in an oral form, with some exceptions. The change means that a Part D enrollee must no longer pay a full month's co-payment or coinsurance for drugs dispensed for less than a 30-day period. The pro-rating applies regardless of the setting where a drug is dispensed.

Proposed Provision

The Chairman's Mark would require the Comptroller General to submit a report to Congress, within eighteen months of enactment, examining the extent to which Medicare Part D and private payers use programs that synchronize pharmacy dispensing schedules so that individuals who are prescribed multiple drugs may receive their medications on the same day to facilitate counseling services and promote medication adherence. The Comptroller would be required to recommend legislative and administrative actions as the Comptroller sees fit.

The report would evaluate the extent to which pharmacies have adopted synchronization programs; look at the common characteristics of the programs, including how pharmacies structure counseling sessions under such programs as well as payment and other arrangements to support pharmacy synchronization efforts; and compare the Medicare programs to private programs. The report would also assess the programs' impact on medication adherence, health outcomes, and patient satisfaction; assess the extent to which Medicare rules support medication synchronization; and examine whether there are barriers to such programs in Medicare.

Section 602: GAO Study and Report on the Impact of Obesity Drugs on Patient Health and Spending

Current Law

Under existing law (SSA Section 1860D-(e)(2)(A)) Medicare Part D excludes coverage of certain drugs or classes of drugs, or their medical uses. Among the excluded drugs are agents used to treat anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose such as a treatment for morbid obesity).

Proposed Provision

The Chairman's Mark would direct the Comptroller General to submit a report to Congress within eighteen months of enactment providing information on the use of prescription drugs to control the weight of obese patients and the impact of coverage on health and spending and to recommend legislative and administrative actions as the Comptroller sees fit. The report would examine use of the drugs in the non-Medicare population and for Medicare beneficiaries who have coverage for weight-loss drugs as a Medicare Advantage supplemental benefit.

The Comptroller General would analyze the prevalence of obesity in the population; the utilization of weight-loss drugs; the distribution of body mass index by those taking weight-loss drugs; and the available information on the use of obesity drugs in conjunction with other health care items or services, such as counseling, and how that compares with the use of other items and services by obese individuals who do not use weight loss drugs.

The Comptroller General also would examine physician considerations in prescribing weight-loss drugs; the prevalence of processes to discontinue use of the drugs for patients who do not benefit; the available information on patient adherence and maintenance of weight loss, and the subsequent impact of obesity drugs on other medical services directly related to obesity; and what is known about the spending associated with the care of individuals who use weight loss drugs compared to those who do not.

Title VII—Offsets

Section 701: Rescission of Funding in the Medicare Improvement Fund

Current Law

Section 188 of the Medicare Improvements for Patient and Providers Act (MIPPA) established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. Under current law, $270 million is available for services furnished during and after FY2021.

Proposed Provision

The Chairman's Mark would eliminate the funding in the MIF.

Section 702: Rescission of Funding in the Medicaid Improvement Fund

Current Law

The Supplemental Appropriations Act, 2008 (P.L. 110-252) amended the Social Security Act established, the Medicaid Improvement Fund, available to the Secretary to improve the management of the Medicaid program. Under current law, $5 million is available for FY2021 and after.

Proposed Provision

The Chairman's Mark would eliminate the funding in the Medicaid Improvement Fund.