114TH CONGRESS
2D SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Mr. HATCH (for himself, Mr. WYDEN, Mr. ISAKSON, and Mr. WARNER) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016''.

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

TITLE I—RECEIVING HIGH QUALITY CARE IN THE HOME

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

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

(1) in subsection (e)—

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

(B) in paragraph (5), by striking ''10,000'' and inserting ''12,000''; and

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

SEC. 102. EXPANDING ACCESS TO HOME DIALYSIS THERAPY.

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

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

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

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

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

''(B) For purposes of subparagraph (A)(ii), an individual determined to have end stage renal disease receiving home dialysis may choose to receive the monthly end stage renal disease-related visits furnished on or after January 1, 2018, via telehealth if the individual receives a face-to-face visit, without the use of telehealth, at least once every three consecutive months.''.

(b) ORIGINATING SITE REQUIREMENTS.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

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

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

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

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

''(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not

apply with respect to telehealth services furnished on or after January 1, 2018, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).''.

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

TITLE II—ADVANCING TEAM-BASED CARE

SEC. 201. ALLOWING END-STAGE RENAL DISEASE BENEFICIARIES TO CHOOSE A MEDICARE ADVANTAGE PLAN.

(a) REMOVING PROHIBITION.—

(1) IN GENERAL.—Section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)) is amended—

(A) by striking subparagraph (B); and

(B) by striking ''ELIGIBLE INDIVIDUAL'' and all that follows through ''In this title, subject to subparagraph (B),'' and inserting ''ELIGIBLE INDIVIDUAL.—In this title,''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1852(b)(1) of the Social Security Act (42 U.S.C. 1395w–22(b)(1)) is amended—

(i) by striking subparagraph (B); and

(ii) by striking ''BENEFICIARIES'' and all that follows through ''A Medicare+Choice organization'' and inserting ''BENEFICIARIES.—A Medicare Advantage organization''.

(B) Section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) is amended, in the second sentence, by striking ''may waive'' and all that follows through ''subparagraph and''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(b) EXCLUDING COSTS FOR KIDNEY ACQUISITIONS FROM MA BENCHMARK.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (k)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''paragraphs (2)

and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

(ii) in subparagraph (B)(i), by striking ''paragraphs (2) and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

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

''(5) EXCLUSION OF COSTS FOR KIDNEY ACQUISITIONS FROM CAPITATION RATES.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d)) in the area for the year.''; and

(2) in subsection (n)(2)—

(A) in subparagraph (A)(i), by inserting ''and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)'' before the semicolon at the end;

(B) in subparagraph (E), in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (G)''; and

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

''(G) APPLICATION OF KIDNEY ACQUISITIONS ADJUSTMENT.—The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.''.

(c) FFS COVERAGE OF KIDNEY ACQUISITIONS.—

(1) IN GENERAL.—Section 1852(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)(i)) is amended by inserting ''or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)'' after ''hospice care''.

(2) CONFORMING AMENDMENT.—Section 1851(i) of the Social Security Act (42 U.S.C. 1395w–21(i)) is amended by adding at the end the following new paragraph:

''(3) FFS PAYMENT FOR EXPENSES FOR KIDNEY ACQUISITIONS.—Paragraphs (1) and (2) shall not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(d) EVALUATION OF QUALITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an evaluation of whether the 5-star quality rating system, based on the data collected under section 1852(e) of the Social Security Act (42 U.S.C. 1395w–22(e)), should include a quality measure specifically related to care for enrollees in Medicare Advantage plans under part C of title XVIII of such Act determined to have end-stage renal disease.

(2) PUBLIC AVAILABILITY.—Not later than April 1, 2020, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services the results of the evaluation under paragraph (1).

(e) REPORT.—Not later than December 31, 2023, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall submit to Congress a report on the impact of the provisions of, and amendments made by, this section with respect to the following:

(1) Spending under—

(A) the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act; and

(B) the Medicare Advantage program under part C of such title.

(2) The number of enrollees determined to have end-stage renal disease—

(A) in the original Medicare fee-for-service program; and

(B) in the Medicare Advantage program.

(3) The sufficiency of the amount of data under the original Medicare fee-for-service program for individuals determined to have end-stage renal disease for purposes of determining payment rates for end-stage renal disease under the Medicare Advantage program.

SEC. 202. PROVIDING CONTINUED ACCESS TO MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR VULNERABLE POPULATIONS.

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

(b) INCREASED INTEGRATION OF DUAL SNPS.—

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

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

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

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

''(8) INCREASED INTEGRATION OF DUAL SNPS.—

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

paragraph and, consistent with such role, shall—

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

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

"(B) UNIFIED GRIEVANCES AND APPEALS PROCESS.—

"(i) IN GENERAL.—Not later than April 1, 2018, the Secretary shall establish procedures, to the extent feasible, unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and 1932(b)(4) for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX. The Secretary shall solicit comment in developing such procedures

from States, plans, beneficiaries and their representatives, and other relevant stakeholders.

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

''(I) adopt the provisions for the enrollee under current law that are most protective for the enrollee and are compatible with unified timeframes and consolidated access to external review under an integrated process;

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

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

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

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

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

''(II) Single pathways for resolution of any grievance or appeal related to a particular item or service provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX.

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

''(IV) Unified timeframes for grievances and appeals processes, such as an individual's filing of a

grievance or appeal, a plan's acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

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

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

"(C) REQUIREMENT FOR UNIFIED GRIEVANCES AND APPEALS.—For 2020 and subsequent years, the contract of a specialized MA

plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under paragraph (3)(D) shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

''(D) REQUIREMENT FOR FULL INTEGRATION OF BEHAVIORAL HEALTH BENEFITS.—For 2021 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall integrate with capitated contracts with States for all Medicaid behavioral health benefits under this title and title XIX.''.

(2) CONFORMING AMENDMENT TO RESPONSIBILITIES OF FEDERAL COORDINATED HEALTH CARE OFFICE.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)) is amended by adding at the end the following new paragraphs:

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

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

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

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

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

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

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

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

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

"(B) IMPROVEMENTS TO CARE MANAGEMENT REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—For 2019 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the requirements described in this paragraph include the following:

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

"(ii) Requirements developed by the Secretary to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis.

"(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the indi-

vidual's individualized care plan under clause (ii)(II) of such subparagraph.

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

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

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

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

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

"(I) before January 1, 2021, have";

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

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

"(II) on or after January 1, 2021, have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under subsection (f)(9)(A).".

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

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

"(A) IN GENERAL.—Not later than December 31, 2019, the Secretary shall convene a panel of clinical advisors to establish a list of conditions that meet each of the following criteria:

"(i) Conditions that meet the definition of a severe or disabling chronic condition under subsection (b)(6)(B)(iii) on or after January 1, 2021.

"(ii) Conditions that—

"(I) require prescription drugs, providers, and models of care that are unique to the specific population of enrollees in a specialized MA plan for special needs individuals described in such subsection on or after such date and would not be needed by the general population of beneficiaries under this title; and

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

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

''(B) UPDATING OF LIST.—Not later than December 31, 2021, and every 5 years thereafter, the Secretary shall convene a panel of clinical advisors to update the list under subparagraph (A), taking into consideration the criteria described in clauses (i) and (ii) of subparagraph (A) and the availability of varied benefits, cost-sharing, and supplemental benefits under the model described in paragraph (2) of section 1859(h), including the expansion under paragraph (1) of such section.''.

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

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

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may require reporting of data under section 1852(e) for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

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

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

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

"(iii) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the

program under this part as a result of the collection of such data.

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

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

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

''(B) CONSIDERATION OF CHANGE.—After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures

at the plan level as described in such subparagraph.''.

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON STATE CONTRACTING WITH MANAGED CARE ENTITIES FOR MEDICAID LONG TERM SERVICES AND SUPPORTS DELIVERY AND WITH DUAL SNPS UNDER MEDICARE ADVANTAGE.—

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

(i) Each State in which the State agency responsible for administering the State plan under such title XIX has a contract with such a specialized MA plan and that delivers long term services and sup-

ports under the State plan under such title XIX through a managed care program, including the requirements under such State plan with respect to long term services and supports.

(ii) Types of such specialized MA plans, which may include the following:

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

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

(III) A plan described in subclause (II) that also meets additional requirements established by the State.

(iii) Characteristics of individuals enrolled in such specialized MA plans.

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

(I) The population of individuals eligible to receive such services and supports.

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

(III) Whether home and community-based services under the State plan are provided on a capitated basis.

(B) REPORT.—Not later than January 1, 2019, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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

(A) STUDY.—The Medicaid and CHIP Payment and Access Commission (in this paragraph referred to as the ''Commission'') shall conduct a study on State-level integration between specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of

section 1859 of the Social Security Act (42 U.S.C. 1395w–28) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.). Such study shall include an analysis of the following:

(i) The impact on spending under a State plan under such title of—

(I) having such a specialized MA plan available in the State; and

(II) delivering long term services and supports under such plan through a managed care program.

(ii) Spending under such title for items and services furnished to such individuals on a fee-for-service basis as compared to a capitated basis through a managed care program.

(iii) The impact of having such a specialized MA plan available in the State on waiting lists, such as whether individuals placed on waiting lists for home and community-based services under the State plan opted to enroll in such a specialized MA plan.

(iv) Change in utilization from the nursing home setting to home and community-based services.

(v) Whether the availability of plans described in section 1853(a)(1)(B)(iv)(II) of such Act (42 U.S.C. 1395w–23(a)(1)(B)(iv)(II)) had an impact on the utilization of, and spending for, items and services covered under such title XVIII, such as whether access to home and community-based services kept enrollees in such plans out of the hospital.

(B) REPORT.—Not later than January 1, 2019, the Commission shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

TITLE III—EXPANDING INNOVATION AND TECHNOLOGY

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

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

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

''(1) IN GENERAL.—In implementing the model described in paragraph (2) proposed to be tested under section 1115A(b), the Secretary shall revise the testing of the model under such section to cover, effective not later than January 1, 2019, all States.

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

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

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

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

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

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

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

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

"(i) IN GENERAL.—For plan year 2019 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

"(ii) SUPPLEMENTAL BENEFITS DESCRIBED.—

"(I) IN GENERAL.—Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

"(II) AUTHORITY TO WAIVE UNIFORMITY REQUIREMENTS.—The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity re-

quirement under subsection (d)(1)(A), as determined appropriate by the Secretary.

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

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

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

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

(b) GAO STUDY AND REPORT.—

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

the Social Security Act. Such study shall include an analysis of the following:

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

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

(C) The impact supplemental benefits have on—

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

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

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

(2) REPORT.—Not later than January 1, 2021, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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

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

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

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

"(m) PROVISION OF ADDITIONAL TELEHEALTH BENEFITS.—

"(1) MA PLAN OPTION.—For plan year 2019 and subsequent plan years, subject to the requirements of paragraph (3), an MA plan may provide additional telehealth benefits (as defined in paragraph (2)) to individuals enrolled under this part.

"(2) ADDITIONAL TELEHEALTH BENEFITS DEFINED.—

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

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

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

"(II) that are identified as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1861(r)) or practitioner (described in section 1842(b)(18)(C)) providing the service is not at the same location as the plan enrollee.

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

"(B) PUBLIC COMMENT.—Not later than November 30, 2017, the Secretary shall solicit comments on what types of telehealth services currently offered to enrollees under this part through supplemental health care benefits should be considered to meet the definition of additional telehealth benefits under this paragraph.

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

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

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

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

"(4) ENROLLEE CHOICE.—If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2)), an individual enrollee

shall have discretion as to whether to receive such service as an additional telehealth benefit.

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

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

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the requirement under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1834(m).''.

(b) CLARIFICATION REGARDING INCLUSION IN BID AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)(ii)(I)) is amended by inserting '', including, for plan year 2019 and subsequent plan years, the provision of additional tele-

health benefits as described in section 1852(m)'' before the semicolon at the end.

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

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

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

''(1) IN GENERAL.—In the case of telehealth services for which payment would otherwise be made under this title furnished on or after January 1, 2019, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

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

''(B) NO APPLICATION OF GEOGRAPHIC LIMITATION.—The geographic limitation under

section 1834(m)(4)(C)(i) shall not apply with respect to an originating site described in section 1834(m)(4)(C)(ii) (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

''(2) DEFINITIONS.—In this subsection:

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

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

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

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

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

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

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

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

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

(b) STUDY AND REPORT.—

(1) STUDY.—

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

(B) COLLECTION OF DATA.—The Secretary may collect such data as the Secretary

determines necessary to carry out the study under this paragraph.

(2) REPORT.—Not later than January 1, 2025, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

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

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

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

''(A) WAIVER OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2018, related to the evaluation of an acute stroke, as determined by the Secretary.

''(B) NO ORIGINATING FACILITY FEE.—The Secretary shall not pay an originating site

facility fee (as described in paragraph (2)(B)) with respect to such telehealth services.''.

TITLE IV—IDENTIFYING THE CHRONICALLY ILL POPULATION

SEC. 401. ENSURING ACCURATE PAYMENT FOR CHRONICALLY ILL INDIVIDUALS.

(a) Section 1853(a)(1) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)) is amended—

(1) in subparagraph (C)(i), by striking ''The Secretary'' and inserting ''Subject to subparagraph (I), the Secretary''; and

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

''(I) IMPROVEMENTS TO RISK ADJUSTMENT FOR 2019 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

''(I) TAKING INTO ACCOUNT TOTAL NUMBER OF DISEASES OR CONDITIONS.—The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary

shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

''(II) USING AT LEAST 2 YEARS OF DIAGNOSTIC DATA.—The Secretary shall use at least 2 years of diagnosis data.

''(III) PROVIDING SEPARATE ADJUSTMENTS FOR DUAL ELIGIBLE INDIVIDUALS.—With respect to individuals who are dually eligible for benefits under this title and title XIX, the Secretary shall make separate adjustments for each of the following:

''(aa) Full-benefit dual eligible individuals (as defined in section 1935(c)(6)).

''(bb) Such individuals not described in item (aa).

''(IV) EVALUATION OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS.—The Secretary shall evaluate the impact of including additional diagnosis codes related to mental

health and substance use disorders in the risk adjustment model.

''(V) EVALUATION OF CHRONIC KIDNEY DISEASE.—The Secretary shall evaluate the impact of including diagnosis codes related to the severity of chronic kidney disease in the risk adjustment model.

''(VI) EVALUATION OF PAYMENT RATES FOR END-STAGE RENAL DISEASE.—The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

''(ii) PHASED-IN IMPLEMENTATION.—The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

''(iii) OPPORTUNITY FOR REVIEW AND PUBLIC COMMENT.—The Secretary shall

provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.''.

(b) STUDIES AND REPORTS.—

(1) REPORTS ON THE RISK ADJUSTMENT SYSTEM.—

(A) MEDPAC EVALUATION AND REPORT.—

(i) EVALUATION.—The Medicare Payment Advisory Commission shall conduct an evaluation of the impact of the provisions of, and amendments made by, this section on risk scores for enrollees in Medicare Advantage plans under part C of title XVIII of the Social Security Act and payments to Medicare Advantage plans under such part, including the impact of such provisions and amendments on the overall accuracy of risk scores under the Medicare Advantage program.

(ii) REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory

Commission shall submit to Congress a report on the evaluation under clause (i), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(B) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than December 31, 2018, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the risk adjustment model and the ESRD risk adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act, including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees.

(2) STUDY AND REPORT ON FUNCTIONAL STATUS.—

(A) STUDY.—The Comptroller General of the United States (in this paragraph referred to

as the ''Comptroller General'') shall conduct a study on how to most accurately measure the functional status of enrollees in Medicare Advantage plans and whether the use of such functional status would improve the accuracy of risk adjustment payments under the Medicare Advantage program under part C of title XVIII of the Social Security Act. Such study shall include an analysis of the challenges in collecting and reporting functional status information for Medicare Advantage plans under such part, providers of services and suppliers under the Medicare program, and the Centers for Medicare & Medicaid Services.

(B) REPORT.—Not later than June 30, 2018, the Comptroller General shall submit to Congress a report containing the results of the study under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 402. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACCOUNTABLE CARE ORGANIZATION.

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

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

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

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

''(2) PROVIDING FLEXIBILITY.—For each agreement period (effective for agreements entered into or renewed on or after January 1, 2019), the following shall apply:

''(A) CHOICE OF PROSPECTIVE ASSIGNMENT.—In the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

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

"(i) IN GENERAL.—The Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

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

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

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

"(iii) SUPERSEDING CLAIMS-BASED ASSIGNMENT.—A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede

any claims-based assignment otherwise determined by the Secretary.''.

TITLE V—EMPOWERING INDIVIDUALS AND CAREGIVERS IN CARE DELIVERY

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

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

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

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

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

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

''(1) PROGRAM.—

"(A) IN GENERAL.—In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary's discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

"(B) IMPLEMENTATION.—The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date shall be no earlier than January 1, 2018, and no later than January 1, 2019.

"(2) CONDUCT OF PROGRAM.—

"(A) DURATION.—Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be

conducted for such period (of not less than 1 year) as the Secretary may approve.

''(B) SCOPE.—An ACO Beneficiary Incentive Program established under this subsection shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who are furnished qualifying services by the ACO:

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

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

''(C) QUALIFYING SERVICE.—For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20

of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

"(i) an ACO professional described in subsection (h)(1)(A) who has a primary specialty designation of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine;

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

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

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

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

"(ii) in the same amount for each Medicare fee-for-service beneficiary described in clauses (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1882(g)(1)), in a State Medicaid plan under title XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

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

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

"(E) NO SEPARATE PAYMENTS FROM THE SECRETARY.—The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this

subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

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

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

''(H) TERMINATION.—The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any

time for reasons determined appropriate by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

(1) The frequency with which services similar to longitudinal comprehensive care planning services are furnished to Medicare beneficiaries, which providers of services and suppliers are furnishing those services, whether Medicare reimbursement is being

received for those services, and, if so, through which codes those services are being reimbursed.

(2) Whether, and the extent to which, longitudinal comprehensive care planning services would overlap, and could therefore result in duplicative payment, with services covered under the hospice benefit as well as the chronic care management code, evaluation and management codes, or other codes that already exist under part B of the Medicare program.

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

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

(5) The feasibility and appropriateness of the Secretary requiring adherence to the care plan as a

condition of Medicare participation and a condition of receiving payment for longitudinal comprehensive care planning services, including how differences in State laws may or may not affect the ability of the Secretary to enforce such requirements.

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

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

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

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

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

(7) How such quality metrics would provide information on—

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

(B) the documentation of the care plan;

(C) services furnished to the beneficiary; and

(D) outcomes of treatment.

(8) What type of training and education is needed for applicable providers, individuals, and caregivers in order to facilitate longitudinal comprehensive care planning services.

(9) Which providers of services and suppliers should be included in the interdisciplinary team of an applicable provider.

(10) Which population of Medicare beneficiaries would be the most appropriate to receive longitudinal comprehensive care planning services, which may include the following:

(A) An individual diagnosed with Alzheimer's disease or other dementia.

(B) An individual diagnosed with metastatic or locally advanced cancer.

(C) An individual diagnosed with late-stage neuromuscular disease.

(D) An individual diagnosed with late-stage diabetes.

(E) An individual diagnosed with late-stage kidney, liver, heart, gastrointestinal, cerebrovascular, or lung disease.

(F) An individual who needs assistance with two or more activities of daily living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) not associated with acute or post-operative conditions that are caused by one or more serious or life-threatening illnesses or frailties.

(11) Whether longitudinal comprehensive care planning services should be furnished more frequently than once upon initial diagnosis, such as once yearly or with each significant progression of the illness.

(b) REPORT.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) DEFINITIONS.—In this section:

(1) APPLICABLE PROVIDER.—The term ''applicable provider'' means a hospice program (as defined in subsection (dd)(2) of section 1861 of the Social

Security Act (42 U.S.C. 1395ww)) or other provider of services (as defined in subsection (u) of such section) or supplier (as defined in subsection (d) of such section) that—

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

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

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

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

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

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

(C) may include other direct care personnel.

(4) LONGITUDINAL COMPREHENSIVE CARE PLANNING SERVICES.—The term ''longitudinal comprehensive care planning services'' means a voluntary shared decision-making process that is furnished by an applicable provider through an inter-

disciplinary team and includes a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness. The purpose of such services is to discuss a longitudinal care plan that addresses the progression of the disease, treatment options, the goals, values, and preferences of the beneficiary, and the availability of other resources and social supports that may reduce the beneficiary's health risks and promote self-management and shared decision making.

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

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

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

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the extent to which Medicare prescription drug plans (MA–PD plans and standalone prescription drug plans) under part D of title XVIII of the Social Security Act and private payors use programs that synchronize pharmacy dispensing so that individuals may receive multiple prescriptions on the same

day to facilitate comprehensive counseling and promote medication adherence. The study shall include an analysis of the following:

(1) The prevalence of such programs.

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

(3) The extent to which common characteristics of such programs are different for Medicare prescription drug plans and private payors.

(4) The impact of such programs on patient medication adherence and, to the extent practicable, overall patient health outcomes and health outcomes by patient subpopulations, such as disease state and socioeconomic status.

(5) To the extent practicable, overall patient satisfaction with such programs and satisfaction with such programs within patient subpopulations, such as disease state and socioeconomic status.

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

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

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

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

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the use of prescription drugs to manage the weight of obese patients and the impact of coverage of such drugs on patient health and on health care spending. Such study shall examine the use and impact of these obesity drugs in the non-Medicare population and for Medicare beneficiaries who have such drugs covered through an MA–PD plan (as defined in section 1860D–1(a)(3)(C) of the Social Security Act (42 U.S.C. 1395w–101(a)(3)(C))) as a supplemental health care benefit. The study shall include an analysis of the following:

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

(2) The utilization of obesity drugs.

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

(4) The extent to which use of obesity drugs is in conjunction with the receipt of other items or services, such as behavioral counseling.

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

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

(7) The extent to which individuals who take obesity drugs adhere to the prescribed regimen.

(8) The extent to which individuals who take obesity drugs maintain weight loss over time.

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

(10) The medical and other items and services received by obese individuals who do not take obesity drugs.

(11) The spending associated with the care of individuals who take obesity drugs, compared to the spending associated with the care of individuals who do not take such drugs.

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

TITLE VII—OFFSETS

SEC. 701. OFFSETS TO BE SUPPLIED.