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THE CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE ACT OF 2017

AUGUST 3, 2017.—Ordered to be printed

Mr. HATCH, from the Committee on Finance, submitted the following

R E P O R T

[To accompany S. 870]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (S. 870) to amend title XVIII of the Social Security Act to implement Medicare payment policies designed to improve management of chronic disease, streamline care coordination, and improve quality outcomes without adding to the deficit, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

CONTENTS

I. LEGISLATIVE BACKGROUND

The Committee on Finance, having considered S. 870, as modified, a bill that would amend title XVIII of the Social Security Act to implement Medicare payment policies designed to improve man-

agement of chronic disease, streamline care coordination, and improve quality outcomes without adding to the deficit, reports favorably thereon that the bill as modified by the Committee and reported with an amendment do pass.

Background and need for legislative action

Over the past two years, the Senate Finance Committee has prioritized work on a key challenge facing the nation's health care system: how to effectively deliver high quality, coordinated medical care to Medicare beneficiaries living with multiple chronic conditions. Chronically ill patients account for a large percentage of overall Medicare spending, which is expected to rise as an increasing number of adults with chronic conditions age into the Medicare program. If not addressed, this could result in worse health outcomes for those with chronic disease as well as higher costs for both beneficiaries and the Medicare program.

On May 22, 2015, Finance Committee Chairman Orrin Hatch (R–UT) and Ranking Member Ron Wyden (D–OR) formed a bipartisan, full committee chronic care working group (CCWG), co-chaired by Senator Johnny Isakson (R–GA) and Senator Mark Warner (D–VA). The working group was tasked with analyzing current law, discussing alternative policy options, and developing bipartisan legislative solutions. To meet this goal, the working group invited all interested stakeholders to submit their best ideas, based on real world experience and data-driven evidence, to improve health outcomes for Medicare beneficiaries with chronic conditions.

After reviewing a first round of 530 comments submitted by the health care community, and subsequently meeting with 80 individual stakeholder groups, the CCWG produced a comprehensive policy options document, which was released on December 18, 2015. Release of the options document was intended to generate further input from Members of Congress and stakeholders as the CCWG refined the policies it believed had the greatest potential to improve care coordination, increase value, and lower costs in the Medicare program without adding to the deficit.

After soliciting a second round of 327 stakeholder comments, the CCWG issued a legislative discussion draft on October 27, 2016. Soon after, the Centers for Medicare & Medicaid Services (CMS), in its calendar year (CY) 2017 Medicare Physician Fee Schedule Rule, finalized four policies proposed in the policy options document. Additionally, two provisions included in the discussion draft—one to improve risk adjustment in the Medicare Advantage (MA) program and another to ensure access to MA plans for Medicare-eligible individuals with end-stage renal disease (ESRD)—were adopted as part of the 21st Century Cures Act (P.L. 114–255), which was signed into law on December 13, 2016.

The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (S. 870), as modified, offers additional solutions to improve health outcomes through policies targeting traditional fee-for-service (FFS), Medicare Advantage (MA), and Accountable Care Organizations (ACOs). The CHRONIC Care Act includes:

- Expansion and extension of the successful Independence at Home (IAH) program, expansion of telehealth services available to home dialysis patients, and greater availability of tele-

health services to help ensure individuals presenting with stroke symptoms receive the best course of treatment;

• Improved flexibility and predictability for MA plans to better serve chronically ill beneficiaries through increased access to value-based insurance design, permanent authorization of special needs plans (SNPs), greater incentives to offer telehealth services, and an expansion of supplemental benefits; and

• Greater flexibility for certain ACOs to provide telehealth services, the option for certain ACOs to provide incentive payments to help patients afford primary care services, and the choice to have beneficiaries assigned to an ACO prospectively instead of retrospectively.

II. EXPLANATION OF THE BILL

A. AMENDS 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

TITLE I—RECEIVING HIGH-QUALITY CARE IN THE HOME

Section 101. Extending the Independence at Home Demonstration Program

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill makes modifications that would extend and expand the IAH demonstration: (1) the maximum length of an agree-

ment 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) the mandatory termination provision is modified so that it would apply only to practices that fail to generate savings against their spending targets for three consecutive years. Currently, a practice is to be terminated if it does not receive an incentive payment for spending at least 5 percent less than its target for two consecutive years. The reported bill also clarifies that the required independent evaluation of the IAH demonstration would include an assessment of IAH medical practice use of electronic health information systems, including remote monitoring, to the extent information is available.

Section 102. Expanding Access to Home Dialysis Therapy

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill 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

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill would permanently authorize SNPs if certain additional policy requirements are met. Rather than expiring under current law 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 ad-

dition, 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; and
  - 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 reported bill 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 and:
  - as a result of access to, and enrollment in, such a specialized MA plan for special needs individuals, individuals with such condition would have a reasonable expectation of slowing or halting the progression of the disease, improving health out-

comes and decreasing overall costs for individuals diagnosed with such condition compared to available options of care other than through such a specialized MA plan for special needs individuals; or

○ 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 reported bill.

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;
- consider the impact of such a change on MA plans that serve a disproportionate number of dually-eligible beneficiaries;
- 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; and
- the efforts of state Medicaid programs to transition dually-eligible beneficiaries receiving LTSS from institutional settings to home and community based settings and related financial impacts of these transitions.

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

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill 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

PRESENT 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).

EXPLANATION OF PROVISION

The reported bill 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 reported bill would require the Comptroller General to conduct a study on the supplemental benefits provided by MA plans. The study, to the extent data are available, 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

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. The Secretary would be required, no later than November 30, 2018, to solicit comments on what types of items and services (including those provided through supplemental health care benefits) should be considered to be additional telehealth benefits and the requirements for the provision or furnishing of such benefits (such as licensure, training, and coordination requirements). The costs of telehealth benefits included in the bid would not include capital and infrastructure related costs or investments. If an MA plan provides a service as an additiontal telehealth service, the MA plan must also provide access to the service through an in-person visit (and not only as an additional telehealth visit), and the beneficiary would have the ability to decide whether or not to receive the services via telehealth. This section would not affect the requirement that MA plans must provide enrollees 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

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill 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 reported bill 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

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill 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

PRESENT 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 connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care.

EXPLANATION OF PROVISION

The reported bill 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

PRESENT 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 con-

tinue to have standard Medicare Part A and B cost-sharing responsibilities, including deductibles and coinsurance payments.

EXPLANATION OF PROVISION

The reported bill 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

PRESENT LAW

No present law.

EXPLANATION OF PROVISION

The reported bill 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. Providing Prescription Drug Plans with Parts A and B Claims Data to Promote the Appropriate Use of Medications and Improve Health Outcomes

PRESENT LAW

Under current law, standalone prescription drug plans (PDPs) provide Medicare's prescription drug benefit to fee-for-service (FFS) beneficiaries. Certain Medicare beneficiaries who meet criteria described in section 1860D–4(c)(2)(a)(ii) of the Social Security Act are eligible to enroll in medication therapy management (MTM) programs offered by PDPs. MTM's purpose is to coordinate prescription drugs for high-cost beneficiaries. However, PDPs do not have access FFS utilization data that may aid the PDP in coordination efforts. This differs from MA–PDs which are responsible for providing both Medicare's prescription drug benefit but also Medicare Part A and Part B's medical benefits and has access to all relevant data.

EXPLANATION OF PROVISION

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

Section 602. Government Accountability Office (GAO) Study and Report on Improving Medication Synchronization

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill would require the Comptroller General to submit a report to Congress, within 18 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 603. GAO Study and Report on the Impact of Obesity Drugs on Patient Health and Spending

PRESENT LAW

Under existing law (Section 1860D–(e)(2)(A) of the Social Security Act) 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).

EXPLANATION OF PROVISION

The reported bill would direct the Comptroller General to submit a report to Congress within 18 months of enactment providing information, to the extent data are available, 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.

Section 604. HHS Study and Report on Long-Term Risk Factors for Chronic Conditions Among Medicare Beneficiaries

PRESENT LAW

No present law.

EXPLANATION OF PROVISION

The reported bill would require the Secretary of Health and Human Services (HHS) to conduct a study to evaluate long-term cost drivers to the Medicare program, including obesity, tobacco use, mental health conditions, and other factors that may con-

tribute to the deterioration of health conditions among individuals with chronic conditions. The study would identify any barriers to collecting and analyzing the information needed to conduct this evaluation and make legislative and regulatory recommendations for removing such barriers. The Secretary would be required to post the resulting report on the HHS public website no later than 18 months after the enactment.

TITLE VII—OFFSETS

Section 701. Rescission of Funding in the Medicare Improvement Fund

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill would eliminate the funding in the Medicare Improvement Fund.

Section 702. Rescission of Funding in the Medicaid Improvement Fund

PRESENT 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.

EXPLANATION OF PROVISION

The reported bill would eliminate the funding in the Medicaid Improvement Fund.

III. BUDGET EFFECTS OF THE BILL

A. Committee Estimates

The Committee adopts as its own the preliminary cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

B. Budget Authority

In compliance with section 308(a)(1) of the Budget Act, the Committee states that the extent to which the provisions of the bill as reported involve new or increased budget authority or affect levels of tax expenditures will be included in the statement from the Congressional Budget Office that will be provided separately, as described in Part C below.

C. CONSULTATION WITH CONGRESSIONAL BUDGET OFFICE

In accordance with section 403 of the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93–344), the Committee advises that the Congressional Budget Office has submitted a cost estimate on the bill. The following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 2017.

Hon. ORRIN G. HATCH,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lori Housman.

Sincerely,

MARK P. HADLEY
(For Keith Hall, Director).

Enclosure.

S. 870—Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act

Summary: S. 870 would affect the Medicare and Medicaid programs in several ways. Specifically, the bill would:

- Modify and extend programs that provide services to beneficiaries with chronic conditions or other special needs,
- Expand use of remote (telehealth) services, and
- Rescind funding dedicated to improving the Medicare fee-for-service program and the management of the Medicaid program.

CBO estimates that enacting S. 870 would not affect direct spending in fiscal year 2018; would reduce direct spending for the Medicare and Medicaid programs by $217 million over the 2018–2022 period; and would have no significant effect on total direct spending over the 2018–2027 period. Pay-as-you-go procedures apply because enacting S. 870 would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2028.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of S. 870 is shown in the following table. The effects of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	By fiscal year, in millions of dollars—												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017–2022	2017–2027
INCREASES OR DECREASES (−) IN DIRECT SPENDING OUTLAYS													
Independence at Home Demonstration	0	0	2	7	7	0	0	0	0	0	0	16	16
Special Needs Plans	0	0	6	13	13	14	14	15	15	16	17	46	123
Value-based Insurance Design Demonstration	0	0	0	40	50	0	0	0	0	0	0	90	90
Telehealth Costs in Medicare Advantage Bids	0	0	0	−10	−10	−10	−10	−10	−10	−10	−10	−30	−80
Telehealth in ACOs	0	0	0	5	5	5	5	5	5	10	10	15	50
Telehealth Services for Stroke Patients	0	0	0	0	10	15	20	25	30	35	45	25	180
Assignment of Beneficiaries to ACOs	0	0	0	5	5	5	5	5	5	10	10	15	50
Use of In-network Providers by ACO Beneficiaries	0	0	0	−5	−7	−7	−7	−7	−7	−7	−7	−19	−54
Rescissions:													
Medicare Program	0	0	0	0	−235	−135	0	0	0	0	0	−370	−370
Medicaid Program	0	0	0	0	−5	0	0	0	0	0	0	−5	−5
Total Changes	0	0	8	55	−167	−113	27	33	38	54	65	−217	0

Notes: Budget authority is equal to outlays.
ACO = accountable care organization.

Basis of estimate: For this estimate, CBO assumes that S. 870 will be enacted near the end of fiscal year 2017.

CBO estimates that enacting S. 870 would affect direct spending in each year, beginning in 2019, by a significant amount, but would have no significant net effect on total direct spending over the 2018–2027 period. The provisions that would affect direct spending are discussed below.

Independence at Home Demonstration. The bill would extend the Independence at Home (IAH) program for two years, through late fiscal year 2019, and would increase the aggregate cap on the number of Medicare beneficiaries served by participating providers from 10,000 to 15,000.

Primary care services provided in a number of settings, including a patient's home, are covered by the Medicare program. The IAH program was established to test whether providing a financial incentive—bonus payments—for providers to deliver primary care services in a patient's home would reduce Medicare spending and improve the quality of care. Providers participating in the IAH program receive a bonus payment if their practice meets quality standards and the average cost of Medicare benefits for its patients is less than 95 percent of the average cost of such benefits for similar patients in the community.[1]

[1] Measuring the cost of similar patients in the community has proved to be a very difficult technical challenge. As a result, each time the evaluators have analyzed the data for a performance year, they have recommended making substantial changes to how those costs will be estimated for a subsequent performance year. Participating providers have been given the choice of continuing to use the existing method or switching to the newly developed method.

Those bonus payments would add to federal costs. The ultimate budgetary effect would depend on whether they resulted in offsetting reductions in Medicare spending. However, determining that the patients served by participating providers have Medicare costs that, on average, are below that 95 percent level does not necessarily indicate that the IAH program reduces Medicare spending, because it does not indicate that the program has changed Medicare's costs for beneficiaries served by participating providers. Expanding the use of home-based services through the IAH program would probably increase the use of certain services, but would ultimately reduce Medicare spending if the resulting change in practice patterns lowered health care costs or if the IAH program shifted market share from higher-cost to lower-cost providers, as long as the resulting savings amounted to more than the bonuses paid through the program. To date, interim evaluations of the IAH program have not assessed whether such changes have occurred. In the absence of such information, CBO has no basis for concluding whether the bonus payments offered through the IAH program have spurred participating providers to make changes affecting Medicare spending.

Further, the bonus payments, as designed, are not targeted exclusively at inducing changes to reduce spending. Instead, providers with relatively low costs would qualify for bonuses whether they make any changes in the way they provide care or not. Similarly, providers who do make changes, but do not lower spending by enough to qualify for a bonus would not receive one. On the basis of the bonus payments made to date, CBO estimates that Medicare would make annual bonus payments to participating providers that average about $5 million per 10,000 beneficiaries for each additional year of the demonstration. Taking into account both the 5,000 increase in the cap on the number of participating beneficiaries and the effect of interactions between changes in spending in the fee-for-service sector and payment rates in the Medicare Advantage (MA) program, CBO estimates that the bill's changes to the IAH program would increase Medicare spending by $16 million over the 2018–2027 period.

Special Needs Plans. Special needs plans (SNPs) are private health insurance plans in the Medicare Advantage program that limit enrollment to beneficiaries who require an institutional level of care, have certain chronic conditions, or are enrolled in both Medicare and Medicaid (dual eligibles). Under current law, the authority for an MA plan to operate as a SNP will expire at the end of calendar year 2018.

S. 870 would permanently authorize SNPs if certain requirements are met. In particular, SNPs that limit enrollment to dual eligibles (D–SNPs) would be required to establish formal agreements with state Medicaid programs by January 1, 2021, to coordinate the provision of Medicaid-covered long-term services and supports (LTSS) or behavioral health services. Feedback from stakeholders indicates that state Medicaid programs find that D–SNPs offer an attractive option for identifying and contracting with private insurers to provide LTSS. Therefore, CBO expects that authorizing D–SNPs beyond 2018 would increase the number and the scope of managed LTSS programs covered by state Medicaid programs.

Based on analysis of information from stakeholders, CBO concludes that managed LTSS plans enroll a small number of individuals who otherwise would receive informal, non-federally financed care in the community. Once those individuals are enrolled in a managed LTSS plan, they would receive Medicaid-financed LTSS for the first time. Compared to current law, CBO estimates that the number of people who would receive Medicaid-financed LTSS under S. 870 would grow over time. That increase would rise to about 1,300 by 2027. CBO estimates that expansion of participation in Medicaid-financed LTSS would increase federal Medicaid outlays by $123 million over the 2018–2027 period. CBO further estimates that permanently authorizing SNPs would not have a significant effect on Medicare spending because CBO estimates that Medicare payments to SNPs, on average, are comparable to Medicare's payments to other MA plans or to providers in the fee-for-service sector.

Value-based Insurance Design (VBID) demonstration. The Center for Medicare and Medicaid Innovation (CMMI) began conducting a demonstration program in January 2017 to test the effectiveness of permitting private health insurance plans participating in the MA program to vary cost-sharing and benefits for Medicare beneficiaries with certain conditions in order to encourage the use of certain services and providers. As with other models tested through the CMMI, the Secretary will be permitted to expand the program if, after evaluating the results of the demonstration program, the Chief Actuary of the Centers for Medicare and Medicaid Services certifies that expansion would not increase Medicare spending and the Secretary determines that the expansion would not reduce quality of care. S. 870 would modify that demonstration project to make VBID available in all 50 states in 2020 and 2021.

Expanding to all 50 states during testing would limit the Secretary's flexibility to design and modify the demonstration. For example, it would be more difficult to focus on elements of the experiment that an initial evaluation suggests might be most promising or to ensure that the demonstration involves a control group that is adequate for the evaluation to produce meaningful conclusions. CBO expects that limiting that flexibility would be unlikely to result in greater savings than a similar model designed and refined under the existing CMMI program but could result in greater costs. Based on that one-sided effect on potential savings, CBO estimates that this provision would increase Medicare spending by a total of $90 million 2020 and 2021. That estimate is in the middle of the range of possible outcomes.

Telehealth costs in Medicare Advantage bids. Under current law, MA plans may provide some telehealth services as part of the standard benefit, mirroring what is covered for beneficiaries enrolled in Medicare's fee-for-service (FFS) program. However, if an MA plan wants to provide telehealth services that go beyond what is covered in the FFS program, the plan must receive approval to provide those services as supplemental benefits and use its "rebate" to pay for those services.[2] S. 870 would allow MA plans to include

[2] The rebate is a portion of the amount by which the "benchmark" amount for the geographic area covered by the plan exceeds the MA plan's bid for services it is required to cover. The benchmark is based on estimated spending per beneficiary in the fee-for-service sector in that geographic area. The rebate portion is between 50 percent and 70 percent, based on the plan's

the cost of additional telehealth services in their bids for contracts that cover 2020 or subsequent years. The costs included in the bid would not include capital or infrastructure expenses. Telehealth services would not count toward meeting network-adequacy requirements, and plans could not use the availability of telehealth services to limit access to in-person services.

Based on a review of the literature and discussions with experts, CBO concluded that coverage of telehealth services by private payers sometimes results in higher spending and sometimes results in savings; in either case, the effects on spending tend to be small. For MA plans that offer telehealth services as supplemental benefits, this provision would increase spending, because Medicare's payment would reflect the full cost of those benefits instead of the 50 percent to 70 percent of the cost that is covered by the rebate. (The other 30 percent to 50 percent is covered by displacing other supplemental benefits that would be attractive to potential enrollees.)

In general, CBO expects that an MA plan that begins or expands coverage of telehealth benefits under S. 870 would do so based on the plan's expectation that it could manage telehealth services in a manner that would enable it to lower its bid. Because coverage of telehealth benefits as a supplemental benefit is very limited, CBO estimates that the savings from plans that begin or expand telehealth services would slightly exceed the increased cost for plans that already offer telehealth services as a supplemental benefit. On net, CBO estimates that enactment of this provision would reduce direct spending by $80 million over the 2018–2027 period.

Telehealth in Accountable Care Organizations. The bill would expand the ability of certain ACOs to receive Medicare payment for telehealth services beginning January 1, 2020. Under current law, Medicare only pays for telehealth services delivered in rural locations, with the remote provider paid under the physician fee schedule and the originating site receiving a facility fee. Nevertheless, an ACO has an incentive to provide noncovered telehealth services if it expects those services to reduce the total cost of care for the ACO's beneficiaries and to result in larger bonus payments from Medicare.

S. 870 would eliminate the geographic component of the originating site requirement for ACOs and allow those programs to receive Medicare payment for certain telehealth services furnished to the ACO's beneficiaries in their homes. No facility fee would be paid for services provided in the home of a beneficiary. CBO estimates that change would increase direct spending for Medicare by $50 million over the 2018–2027 period.

Telehealth Services for Stroke Patients. Under current law, coverage of telehealth services is restricted to Medicare beneficiaries in rural areas. Beginning on January 1, 2021, S. 870 would remove that geographic restriction for telestroke services (a subset of telehealth services that involves consultation with a neurologist for a patient suspected of having had a stroke).

There are two types of stroke: bleeding in the brain (hemorrhagic) and clotting in the brain (ischemic). Use of a clot-dissolving

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score on certain measures of quality of care. MA plans are required to use the rebate to pay for benefits not covered in the fee-for-service sector.

drug to treat clotting strokes within three to four-and-a-half hours of the onset of symptoms substantially improves outcomes, both by increasing survival rates and by reducing the likelihood that a stroke patient will be moderately or severely disabled. However, administering the clot-dissolving drug to a patient with a bleeding stroke is likely to cause death. Therefore, a timely neurological evaluation is essential to determine whether to administer the clot-dissolving drug to a patient with stroke symptoms.

Emergency medical services in most urban and suburban areas have protocols to identify patients with stroke symptoms and transport those patients directly to a hospital that is a "stroke center." As a result, a large majority of stroke patients in those areas are taken directly to a stroke center. Such a facility always has a neurologist available—either onsite or via telehealth—to determine which drugs to administer to a stroke patient, so enacting S. 870 would not affect outcomes for such patients.

On the basis of an analysis of Medicare claims data, a review of the relevant literature, and discussions with experts, CBO estimates that about 550,000 strokes occur in the Medicare population in nonrural settings each year. Under S. 870, by CBO's estimates, the proportion of those cases that is handled using telestroke services would increase from about 6 percent in 2021 to 14 percent in 2027.

To develop spending estimates for the bill's extension of telestroke services, CBO focused on cohorts of Medicare patients who receive a telestroke consultation in a given year. That approach, which tracks groups of patients over a span, is particularly appropriate when spending is changeable over time. On the basis of a review of the relevant literature and discussions with experts, CBO concluded that spending—by the federal government and nonfederal providers combined—for a cohort would increase in the year in which the telestroke consultation occurs and then decline in subsequent years.

Higher spending in the first year would be the result of: additional consultations, more medications, additional treatment, and—for patients who otherwise would not have survived—more spending for post-acute-care services during the 90 days after a hospital stay. Annual spending would be lower in subsequent years largely because the number of patients who are discharged from the hospital with moderate or severe disability would decline significantly as would spending for long-term care.

Because Medicare does not cover long-term care services such as nursing home care, much of the savings from avoided long-term-care services would accrue to beneficiaries, other private payers, and state Medicaid programs—and not to the federal government. The federal government would share in the savings that accrue to state Medicaid programs.

For a given cohort, CBO estimates that cumulative spending—including spending by nonfederal payers—would be reduced beginning in the fourth year after the telestroke consultation. Federal spending would follow the same basic pattern but with a lag because much of the savings would accrue to nonfederal payers. CBO estimates that federal spending would be reduced beginning in the sixth year after the telestroke consultation.

Taking into account that pattern of an initial increase in spending and a reduction over time for each cohort of patients each year, CBO expects that expanding Medicare coverage of telestroke services ultimately would reduce Medicare spending. Over the 2018–2027 period, however, CBO estimates the expansion of telestroke services would increase direct spending by $180 million.

Assignment of beneficiaries to accountable care organizations. In general, Medicare beneficiaries are assigned to an ACO when they receive much of their primary care from providers affiliated with a particular ACO. For most ACOs, assignment of their beneficiaries is retrospective—that is, final assignment of a beneficiary occurs after analysis of the beneficiary's claims for a year. S. 870 would allow ACOs to have beneficiaries assigned to them prospectively beginning in 2020. CBO estimates that this provision would increase federal spending by $50 million over the 2018–2027 period. That conclusion is based on two factors: First, prospective assignment would result in some beneficiaries being assigned to an ACO who would not be assigned to any ACO under current law. That increase in assignment rates would result in an increase in the number of beneficiaries for whom Medicare makes a "shared-savings" payment to an ACO. Second, it would also weaken the incentive for an ACO to lower costs for beneficiaries who are not assigned to it.

Use of in-network providers by AOC beneficiaries. Under current law, health care providers generally are prohibited from offering financial incentives to Medicare beneficiaries to patronize the provider. S. 870 would waive that prohibition with respect to financial incentives offered by certain ACOs to beneficiaries who receive primary care services from a provider within the ACO's network. CBO estimates that enacting that provision of S. 870 would reduce direct spending for Medicare by $54 million over the 2018–2027 period.

Eligible ACOs would have two potential reasons to offer financial incentives for patients to use primary care providers in their networks. The first would be to increase volume at the expense of providers that are not part of the ACO's network, which would affect providers' incomes, but would not have a significant effect on Medicare spending. The second reason is because the ACO would expect that, on average, a dollar spent on financial incentives would be more than offset by higher "shared-savings" payments. Because shared-savings payments would increase only if Medicare spending was lower, CBO expects that eligible ACOs would use those incentive payments in ways that would result in lower Medicare spending relative to current law.

Rescissions. S. 870 would rescind amounts earmarked for making improvements to the Medicare fee-for-service program and to managing the Medicaid program. CBO estimates those rescissions would reduce direct spending for Medicare by $370 million and would reduce federal spending for Medicaid by $5 million.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR S. 870, AS ORDERED REPORTED BY THE SENATE COMMITTEE ON FINANCE ON MAY 18, 2017

	By fiscal year, in millions of dollars—												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017–2022	2017–2027
	NET INCREASE OR DECREASE (−) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	0	8	55	−167	−113	27	33	38	54	65	−217	0

Increase in long-term direct spending and deficits: CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2028.

Intergovernmental and private-sector impact: S. 870 contains no intergovernmental or private-sector mandates as defined in UMRA. CBO estimates that the state share of increased Medicaid spending for higher enrollment in LTSS plans would total $93 million over the 2018–2027 period. Because states have significant flexibility to adjust their financial and programmatic responsibilities, such additional expenditures would not result from an intergovernmental mandate as defined in UMRA.

Estimate prepared by: Federal costs: Alice Burns, Lori Housman, Jamease Kowalczyk, Kevin McNellis, Andrea Noda, Lisa Ramirez-Branum, Lara Robillard, Colin Yee, Rebecca Yip; impact on state, local, and tribal governments: Zachary Byrum; impact on the private sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the Committee states that, with a majority present, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 was ordered favorably reported by a roll call vote of 26 ayes and 0 nays on May 18, 2017.

V. REGULATORY IMPACT AND OTHER MATTERS

A. Regulatory Impact

Pursuant to paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill.

Impact on individuals and businesses, personal privacy and paperwork

In carrying out the provisions of the bill, there is no expected imposition of additional administrative requirements or regulatory burdens on individuals or businesses. The provisions of the bill do not impact personal privacy.

B. UNFUNDED MANDATES STATEMENT

The Committee adopts as its own the estimate of federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act of 1995 (P.L. 104–4). The Congressional Budget Office estimates the bill would not impose intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill as reported by the Committee).