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114TH CONGRESS
2D SESSION

S. 2498

To amend title XVIII of the Social Security Act to establish a pilot program to improve care for the most costly Medicare fee-for-service beneficiaries through the use of comprehensive and effective care management while reducing costs to the Federal Government for these beneficiaries, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 4, 2016

Mr. BENNET (for himself and Mr. PORTMAN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to establish a pilot program to improve care for the most costly Medicare fee-for-service beneficiaries through the use of comprehensive and effective care management while reducing costs to the Federal Government for these beneficiaries, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Program Linking Uncoordinated Services (PLUS) Act''.

SEC. 2. PROGRAM TO IMPROVE CARE FOR HIGHEST COST MEDICARE FEE-FOR-SERVICE BENEFICIARIES.

Title XVIII of the Social Security Act is amended by inserting after section 1866E (42 U.S.C. 1395cc–5) the following new section:

''PROGRAM TO IMPROVE CARE FOR HIGHEST COST MEDICARE FEE-FOR-SERVICE BENEFICIARIES

''SEC. 1866F. (a) ESTABLISHMENT.—The Secretary shall conduct under this section a pilot program (in this section referred to as the 'program') to demonstrate improvements in patient care and cost savings for the highest cost Medicare fee-for-service beneficiaries through enrollment of such beneficiaries with participating organizations. Under the program, the Secretary shall, through a competitive process, enter into a contract with one or two selected organizations to offer benefits for items and services in service areas identified under subsection (b)(1)(A) to the highest cost Medicare fee-for-service beneficiaries (identified under subsection (c)(1)) in the service area involved. The program shall be designed in a manner to provide comprehensive and integrated care management and services through a network of health care providers to meet the specialized needs of such identified beneficiaries.

''(b) CONDUCT OF PROGRAM.—

''(1) PERIOD OF OPERATION AND SCOPE.—

"(A) INITIAL CONDUCT.—The program shall initially be conducted over a 3-year period, beginning not later than 1 year after the date of the enactment of this section, in at least 4 service areas, each identified by the Secretary and each including at least 3 contiguous counties.

"(B) EXPANSION AND EXTENSION.—The Secretary may expand the program to additional service areas and extend its duration if the Secretary determines, in consultation with the Chief Actuary of the Centers for Medicare & Medicaid Services, that such expansion and extension will result in additional savings to the Medicare program and will meet the quality performance standards established under subsection (d)(3)(A)(iii).

"(C) RELATION TO PART D.—

"(i) IN GENERAL.—The Secretary shall design and implement the program in such manner as to preserve the operation of part D, including payment, noninterference, and beneficiary protections under such part.

"(ii) COORDINATION MECHANISMS.—The Secretary shall identify mechanisms that may be used, in the case of a highest cost Medicare fee-for-service beneficiary who is enrolled with a participating organization under the program and in a prescription drug plan offered by a PDP sponsor under part D or a qualified retiree prescription drug plan offered by a sponsor under section 1860D–22, in order to enhance coordination of the individual's care between the organization and the respective sponsor.

"(2) NUMBER OF PARTICIPATING ORGANIZATIONS PER SERVICE AREA.—Under the program the Secretary shall enter into a contract with at least one selected organization (and no more than 2 selected organizations) in each service area identified and covered under the program.

"(c) IDENTIFICATION AND ENROLLMENT OF HIGHEST COST MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

"(1) IDENTIFICATION.—

"(A) IN GENERAL.—For purposes of the program, the Secretary shall develop criteria to

identify, subject to subparagraph (B), Medicare fee-for-service beneficiaries with projected total costs under parts A and B in the highest 15th percentile of all Medicare fee-for-service beneficiaries on an ongoing basis. Such criteria shall be developed in a manner so as to identify such beneficiaries using the most recent national data available for a 2-year period.

''(B) REFINEMENT OF ELIGIBILITY CRITERIA.—In identifying highest cost Medicare fee-for-service beneficiaries under this paragraph, the Secretary shall develop such criteria in a manner that eliminates, to the extent practicable, the identification of individuals who otherwise appear to meet such criteria only because of a single, isolated high-cost incident, item, or service.

''(2) ELIGIBLE BENEFICIARY INITIAL OUTREACH.—The Secretary shall inform the highest cost Medicare fee-for-service beneficiaries residing in an area covered by the program and provide them with information about the program and the process for enrollment and disenrollment from participating organizations in such area. Such information shall include information about such organizations, about

rights and protections under the program, a contact telephone number where beneficiaries can obtain additional information about the program, and the use of an advance directive (as defined in section 1866(f)(3)) in connection with participation in the program.

''(3) AUTO-ENROLLMENT AND DISENROLLMENT PROCEDURES.—

''(A) IN GENERAL.—Under the program, the highest cost Medicare fee-for-service beneficiaries residing in a service area covered under the program—

''(i) shall be enrolled, in a form and manner specified by the Secretary, with a participating organization offered under the program to such a resident in such area; and

''(ii) may change or terminate such enrollment in a form and manner so specified.

In specifying such form and manner, the Secretary shall take into account the form and manner in which individuals may change or terminate an enrollment under a Medicare Advantage plan under part C, including permitting

special disenrollment periods described in section 1851(e)(4).

''(B) DEFAULT ORGANIZATION SELECTION.—In carrying out subparagraph (A), if there are two participating organizations in a service area, the Secretary shall identify, to the extent possible, and enroll the beneficiary in the participating organization which has providers in its network from whom the beneficiary has received services under the Medicare fee-for-service program in the previous year.

''(C) TIMEFRAMES.—In carrying out subparagraph (A), there shall be an initial enrollment period of 12 months, during which a highest cost Medicare fee-for-service beneficiary may also opt out of participation in the program.

''(4) EXTENSION OF CERTAIN GUARANTEED ISSUANCE RIGHTS TO MEDIGAP COVERAGE IN CASE OF DISENROLLMENT.—Subparagraph (A) of section 1882(s)(3) shall apply to a Medicare beneficiary enrolled with a participating organization under this section who had previous coverage under a medicare supplemental insurance policy and who terminates enrollment with the participating organization in the same manner as such section applies to an individual

described in subparagraph (B)(v) of such section with respect to enrollment with a health plan, regardless of the time period of participation in the program and without regard to subparagraph (E)(ii) of such section.

''(5) TREATMENT OF MEDICARE FEE-FOR-SERVICE BENEFITS TO ENROLLEES THROUGH PROGRAM.—The provisions of section 1851(i) shall apply to individuals enrolled with a participating organization under the program in the same manner as they apply to an individual enrolled in a Medicare Advantage plan under part C.

''(6) RELATION TO PART D, EMPLOYER-BASED PRESCRIPTION DRUG COVERAGE, AND MEDICARE SUPPLEMENTAL COVERAGE.—Except as specifically provided, nothing in this section shall be construed as intended to impact benefits or coverage furnished under a prescription drug plan under part D, under a group health plan (including under a qualified retiree prescription drug plan as defined in section 1860D–22(a)(2)), or under a medicare supplemental policy.

''(d) PARTICIPATING ORGANIZATION REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of participating in the program, except as provided in this subsection, a participating organization must meet the same requirements that apply to a Medicare Advantage organization and an MA plan that is not an MA–PD plan under part C, including requirements relating to—

''(A) coverage of items and services under parts A and B; and

''(B) beneficiary protections under part C.

''(2) WAIVER AUTHORITY.—Under the program, the Secretary may waive the requirements of this title and title XI but only to the extent necessary to permit participating organizations—

''(A) to provide care management, custodial care, transportation, in-home assistance, and other services that are not otherwise covered under this title;

''(B) to structure patient incentives, such as a reduction or elimination of cost-sharing, for services and benefits under parts A and B and the use of in-home technology, to improve beneficiary adherence to treatment protocols and the effectiveness of treatment for enrolled

beneficiaries with chronic clinical conditions; and

"(C) to maintain provider and pharmacy networks that do not otherwise meet network adequacy standards.

"(3) QUALITY AND REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—Under the program, the Secretary shall—

"(i) determine appropriate measures (including, to the extent feasible, outcome measures) to assess the quality of care being provided under the program;

"(ii) establish requirements for participating organizations to report, in a form and manner specified by the Secretary, information on such measures;

"(iii) establish quality performance standards on such measures to assess the quality of care being provided by such organizations under the program; and

"(iv) seek the input of stakeholders (in a manner similar to that provided for under section 1848(r)) in determining such measures, requirements, and standards.

"(B) TERMINATION OF PARTICIPATION FOR FAILURE TO MEET QUALITY PERFORMANCE STANDARDS.—The Secretary may terminate participation of an organization under the program for failure to meet the quality performance standards established under subparagraph (A)(iii).

"(C) QUALITY PERFORMANCE STANDARDS.—In establishing quality performance standards under subparagraph (A)(iii) in the case of—

"(i) a provider-based organization (such as an accountable care organization), the Secretary may apply the quality measurement system used under the Medicare shared savings program under section 1899(b)(3); and

"(ii) an MA organization, the Secretary may require that only an organization with a rating (under the star quality rating system under section 1853(o)(4)) of 4 stars or higher be permitted to participate in the program.

"(4) USE OF INTEGRATED MODEL OF CARE.—The Secretary shall develop care management re-

quirements for participating organizations that provides an integrated care model and that includes the following elements:

"(A) Provision of person-centered, comprehensive, and integrated care management and services.

"(B) Provision of services through—

"(i) the use of a network of providers characterized as best-in-class, such as centers of excellence; and

"(ii) the use of an interdisciplinary management team that includes a nurse coordinator (or other appropriate health care professional) assigned to each enrolled beneficiary and that shares a common health information technology platform.

"(C) An evidence-based model of care with appropriate networks of providers and specialists.

"(D) For each beneficiary enrolled with the organization under the program, the organization—

"(i) conducts an initial assessment and an annual reassessment of the beneficiary's physical, psychosocial, and func-

tional needs, including an evaluation and plan with respect to the beneficiary's chronic conditions;

"(ii) provides for regular in-person visits to the beneficiary by a care provider and provides the beneficiary with access to a specialized team, including a hospitalist physician; and

"(iii) develops a plan, in consultation with the beneficiary as feasible, that identifies goals and objectives with respect to the beneficiary, including measurable outcomes as well as specific services and benefits to be provided.

"(e) PAYMENTS.—

"(1) IN GENERAL.—For each individual enrolled with a participating organization under the program, the Secretary shall make a monthly capitated payment to the organization in the same manner as such a payment would be made under part C for an individual enrolled in an MA-plan (that was not an MA–PD plan) offered by a Medicare Advantage organization, except that—

"(A) notwithstanding section 1853, the amount of the payment shall be determined,

subject to subparagraph (B), in an amount equivalent to 98 percent of the projected cost, under the Medicare fee-for-service program under parts A and B for the highest cost Medicare fee-for-service beneficiaries; and

''(B) the amount of such payment shall be adjusted, in a manner specified by the Secretary, to take into account differences in costs among different geographic areas and among high cost Medicare fee-for-service beneficiaries (including outlier costs for the most costly of such beneficiaries).

''(2) PROJECTION BASED UPON HISTORICAL DATA.—In applying paragraph (1)(A), the Secretary shall use historical fee-for-service spending and enrollment data for the highest cost Medicare fee-for-service beneficiaries, trended forward to the first year of the program, and, for subsequent years of the program, increased by projected growth in such spending for such beneficiaries.

''(3) RELATIONSHIP TO PAYMENT FOR COVERED PART D DRUGS.—In the case of an individual who is enrolled with a participating organization under the program—

''(A) if the individual is enrolled with a prescription drug plan under part D, payment for covered part D drugs for such individual is made under such prescription drug plan under such part and not under the program; and

''(B) if the individual is covered under a qualified retiree prescription drug plan under section 1860D–22, payment for covered part D drugs for such individual is made under such plan and not under the program.

''(f) EVALUATION AND REPORT TO CONGRESS.—

''(1) EVALUATION.—The Secretary shall conduct an independent evaluation of the program. Such evaluation shall include an analysis of the impact of the program on coordination of care, expenditures by participating organizations and plans, the program's impact on reducing expenditures under this title, beneficiary access to services and providers, the quality of health care services furnished to beneficiaries, and beneficiary experiences with auto-enrollment and disenrollment under the program.

''(2) REPORT.—Not later than 2 years after the date that Medicare beneficiaries are first enrolled under the program, the Secretary shall submit to

Congress a report on the performance of the program. Such report shall include the results of the evaluation conducted under paragraph (1) and the program's impact on reducing expenditures under this title and on improving the quality of care for the highest cost Medicare fee-for-service beneficiaries enrolled under the program.

''(g) DEFINITIONS.—In this section:

''(1) HIGHEST COST MEDICARE FEE-FOR-SERVICE BENEFICIARY.—The term 'highest cost Medicare fee-for-service beneficiary' means a Medicare fee-for-service beneficiary who has been identified under subsection (c).

''(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—The term 'Medicare fee-for-service beneficiary' means an individual who—

''(A) is entitled to benefits under part A, and enrolled under part B, regardless of the basis for entitlement or eligibility to benefits under any such part; and

''(B) is not enrolled in a Medicare Advantage plan under part C.

''(3) PROGRAM.—Unless the context indicates otherwise, the term 'program' means the program under this section.

''(4) PARTICIPATING ORGANIZATION.—The term 'participating organization' means a selected organization that has entered into a contract to participate in the program.

''(5) SELECTED ORGANIZATION.—The term 'selected organization' means a provider-based organization (such as an accountable care organization) or MA organization (as defined for purposes of part C) that the Secretary determines—

''(A) meets the requirements to provide services to the highest cost Medicare fee-for-services beneficiaries under the program; and

''(B) is accredited by the National Committee for Quality Assurance or otherwise is certified as meeting quality standards.''.

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