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114TH CONGRESS
1ST SESSION

H. R. 3244

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 HOUSE OF REPRESENTATIVES

JULY 28, 2015

Mrs. MCMORRIS RODGERS (for herself, Mr. LARSON of Connecticut, Mr. REED, and Mr. SCHRADER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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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.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the ''Providing Innovative
3 Care for Complex Cases Demonstration Act of 2015''.

4 **SEC. 2. PROGRAM TO IMPROVE CARE FOR HIGHEST COST**
5 **MEDICARE FEE-FOR-SERVICE BENE-**
6 **FICIARIES.**

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

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

12 ''SEC. 1866F. (a) ESTABLISHMENT.—The Secretary
13 shall conduct under this section a pilot program (in this
14 section referred to as the 'program') to demonstrate im-
15 provements in patient care and cost savings for the high-
16 est cost Medicare fee-for-service beneficiaries through en-
17 rollment of such beneficiaries with participating organiza-
18 tions. Under the program, the Secretary shall, through a
19 competitive process, enter into a contract with one or two
20 selected organizations to offer benefits for items and serv-
21 ices in service areas identified under subsection (b)(1)(A)
22 to the highest cost Medicare fee-for-service beneficiaries
23 (identified under subsection (c)(1)) in the service area in-
24 volved. The program shall be designed in a manner to pro-
25 vide comprehensive and integrated care management and

1 services through a network of health care providers to
2 meet the specialized needs of such identified beneficiaries.
3 "(b) CONDUCT OF PROGRAM.—
4 "(1) PERIOD OF OPERATION AND SCOPE.—
5 "(A) INITIAL CONDUCT.—The program
6 shall initially be conducted over a 3-year period,
7 beginning not later than 1 year after the date
8 of the enactment of this section, in at least 4
9 service areas, each identified by the Secretary
10 and each including at least 3 contiguous coun-
11 ties.
12 "(B) EXPANSION AND EXTENSION.—The
13 Secretary may expand the program to addi-
14 tional service areas and extend its duration if
15 the Secretary determines, in consultation with
16 the Chief Actuary of the Centers for Medicare
17 & Medicaid Services, that such expansion and
18 extension will result in additional savings to the
19 Medicare program and will meet the quality
20 performance standards established under sub-
21 section (d)(3)(A)(iii).
22 "(C) RELATION TO PART D.—
23 "(i) IN GENERAL.—The Secretary
24 shall design and implement the program in
25 such manner as to preserve the operation

1 of part D, including payment, noninter-
2 ference, and beneficiary protections under
3 such part.

4 "(ii) COORDINATION MECHANISMS.—
5 The Secretary shall identify mechanisms
6 that may be used, in the case of a highest
7 cost Medicare fee-for-service beneficiary
8 who is enrolled with a participating organi-
9 zation under the program and in a pre-
10 scription drug plan offered by a PDP
11 sponsor under part D or a qualified retiree
12 prescription drug plan offered by a sponsor
13 under section 1860D–22, in order to en-
14 hance coordination of the individual's care
15 between the organization and the respec-
16 tive sponsor.

17 "(2) NUMBER OF PARTICIPATING ORGANIZA-
18 TIONS PER SERVICE AREA.—Under the program the
19 Secretary shall enter into a contract with at least
20 one selected organization (and no more than 2 se-
21 lected organizations) in each service area identified
22 and covered under the program.

23 "(c) IDENTIFICATION AND ENROLLMENT OF HIGH-
24 EST COST MEDICARE FEE-FOR-SERVICE BENE-
25 FICIARIES.—

1 "(1) IDENTIFICATION.—
2 "(A) IN GENERAL.—For purposes of the
3 program, the Secretary shall develop criteria to
4 identify, subject to subparagraph (B), Medicare
5 fee-for-service beneficiaries with projected total
6 costs under parts A and B in the highest 10th
7 percentile of all Medicare fee-for-service bene-
8 ficiaries on an ongoing basis. Such criteria shall
9 be developed in a manner so as to identify such
10 beneficiaries using the most recent national
11 data available for a 2-year period.
12 "(B) REFINEMENT OF ELIGIBILITY CRI-
13 TERIA.—In identifying highest cost Medicare
14 fee-for-service beneficiaries under this para-
15 graph, the Secretary shall develop such criteria
16 in a manner that eliminates, to the extent prac-
17 ticable, the identification of individuals who oth-
18 erwise appear to meet such criteria only be-
19 cause of a single, isolated high-cost incident,
20 item, or service.
21 "(2) ELIGIBLE BENEFICIARY INITIAL OUT-
22 REACH.—The Secretary shall inform the highest cost
23 Medicare fee-for-service beneficiaries residing in an
24 area covered by the program of the program and
25 provide them with information about the program

1 and the process for enrollment and disenrollment
2 from participation organizations in such area. Such
3 information shall include information about such or-
4 ganizations, about rights and protections under the
5 program, a contact telephone number where bene-
6 ficiaries can obtain additional information about the
7 program, and the use of an advance directive (as de-
8 fined in section 1866(f)(3)) in connection with par-
9 ticipation in the program.

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

12 ''(A) IN GENERAL.—Under the program,
13 the highest cost Medicare fee-for-service bene-
14 ficiaries residing in a service area covered under
15 the program—

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

21 ''(ii) may change or terminate such
22 enrollment in a form and manner so speci-
23 fied.

24 In specifying such form and manner, the Sec-
25 retary shall take into account the form and

1 manner in which individuals may change or ter-
2 minate an enrollment under a Medicare Advan-
3 tage plan under part C, including permitting
4 special disenrollment periods described in sec-
5 tion 1851(e)(4).

6 "(B) DEFAULT ORGANIZATION SELEC-
7 TION.—In carrying out subparagraph (A), if
8 there are two participating organizations in a
9 service area, the Secretary shall identify, to the
10 extent possible, and enroll the beneficiary in the
11 participating organization which has providers
12 in its network from whom the beneficiary has
13 received services under the Medicare fee-for-
14 service program in the previous year.

15 "(C) TIMEFRAMES.—In carrying out sub-
16 paragraph (A), there shall be an initial enroll-
17 ment period of 12 months, during which a high-
18 est cost Medicare fee-for-service beneficiary may
19 also opt out of participation in the program.

20 "(4) EXTENSION OF CERTAIN GUARANTEED
21 ISSUANCE RIGHTS TO MEDIGAP COVERAGE IN CASE
22 OF DISENROLLMENT.—Subparagraph (A) of section
23 1882(s)(3) shall apply to a Medicare beneficiary en-
24 rolled with a participating organization under this
25 section who had previous coverage under a medicare

1 supplemental insurance policy and who terminates
2 enrollment with the participating organization in the
3 same manner as such section applies to an individual
4 described in subparagraph (B)(v) of such section
5 with respect to enrollment with a health plan, re-
6 gardless of the time period of participation in the
7 program and without regard to subparagraph (E)(ii)
8 of such section.

9 "(5) TREATMENT OF MEDICARE FEE-FOR-SERV-
10 ICE BENEFITS TO ENROLLEES THROUGH PRO-
11 GRAM.—The provisions of section 1851(i) shall apply
12 to individuals enrolled with a participating organiza-
13 tion under the program in the same manner as they
14 apply to an individual enrolled in a Medicare Advan-
15 tage plan under part C.

16 "(6) RELATION TO PART D, EMPLOYER-BASED
17 PRESCRIPTION DRUG COVERAGE, AND MEDICARE
18 SUPPLEMENTAL COVERAGE.—Except as specifically
19 provided, nothing in this section shall be construed
20 as intending to impact on benefits or coverage fur-
21 nished under a prescription drug plan under part D,
22 under a group health plan (including under a quali-
23 fied retiree prescription drug plan as defined in sec-
24 tion 1860D–22(a)(2)), or under a medicare supple-
25 mental policy.

1 "(d) PARTICIPATING ORGANIZATION REQUIRE-
2 MENTS.—
3 "(1) IN GENERAL.—For purposes of partici-
4 pating in the program, except as provided in this
5 subsection, a participating organization must meet
6 the same requirements that apply to a Medicare Ad-
7 vantage organization and an MA plan that is not an
8 MA–PD plan under part C, including requirements
9 relating to—
10 "(A) coverage of items and services under
11 parts A and B; and
12 "(B) beneficiary protections under part C.
13 "(2) WAIVER AUTHORITY.—Under the pro-
14 gram, the Secretary may waive the requirements of
15 this title and title XI but only to the extent nec-
16 essary to permit participating organizations—
17 "(A) to provide care management, custo-
18 dial care, transportation, in-home assistance,
19 and other services that are not otherwise cov-
20 ered under this title;
21 "(B) to structure patient incentives, such
22 as a reduction or elimination of cost-sharing,
23 for services and benefits under parts A and B
24 and the use of in-home technology, to improve
25 beneficiary adherence to treatment protocols

1 and the effectiveness of treatment for enrolled
2 beneficiaries with chronic clinical conditions;
3 and
4 “(C) to maintain provider and pharmacy
5 networks that do not otherwise meet network
6 adequacy standards.
7 “(3) QUALITY AND REPORTING REQUIRE-
8 MENTS.—
9 “(A) IN GENERAL.—Under the program,
10 the Secretary shall—
11 “(i) determine appropriate measures
12 (including, to the extent feasible, outcome
13 measures) to assess the quality of care
14 being provided under the program;
15 “(ii) establish requirements for par-
16 ticipating organizations to report, in a
17 form and manner specified by the Sec-
18 retary, information on such measures;
19 “(iii) establish quality performance
20 standards on such measures to assess the
21 quality of care being provided by such or-
22 ganizations under the program; and
23 “(iv) seek the input of stakeholders
24 (in a manner similar to that provided for

1 under section 1848(r)) in determining such
2 measures, requirements, and standards.

3 "(B) TERMINATION OF PARTICIPATION
4 FOR FAILURE TO MEET QUALITY PERFORMANCE
5 STANDARDS.—The Secretary may terminate
6 participation of an organization under the pro-
7 gram for failure to meet the quality perform-
8 ance standards established under subparagraph
9 (A)(iii).

10 "(C) QUALITY PERFORMANCE STAND-
11 ARDS.—In establishing quality performance
12 standards under subparagraph (A)(iii) in the
13 case of—

14 "(i) a provider-based organization
15 (such as an accountable care organization),
16 the Secretary may apply the quality meas-
17 urement system used under the Medicare
18 shared savings program under section
19 1899(b)(3); and

20 "(ii) an MA organization, the Sec-
21 retary may require that only an organiza-
22 tion with a rating (under the star quality
23 rating system under section 1853(o)(4)) of
24 4 stars or higher be permitted to partici-
25 pate in the program.

1 "(4) USE OF INTEGRATED MODEL OF CARE.—
2 The Secretary shall develop care management re-
3 quirements for participating organizations that pro-
4 vides an integrated care model and that includes the
5 following elements:
6 "(A) Provision of person-centered, com-
7 prehensive, and integrated care management
8 and services.
9 "(B) Provision of services through—
10 "(i) the use of a network of providers
11 characterized as best-in-class, such as cen-
12 ters of excellence; and
13 "(ii) the use of an interdisciplinary
14 management team that includes a nurse
15 coordinator (or other appropriate health
16 care professional) assigned to each enrolled
17 beneficiary and that shares a common
18 health information technology platform.
19 "(C) An evidence-based model of care with
20 appropriate networks of providers and special-
21 ists.
22 "(D) For each beneficiary enrolled with
23 the organization under the program, the organi-
24 zation—

1 "(i) conducts an initial assessment
2 and an annual reassessment of the bene-
3 ficiary's physical, psychosocial, and func-
4 tional needs, including an evaluation and
5 plan with respect to the beneficiary's
6 chronic conditions;
7 "(ii) provides for regular in-person
8 visits to the beneficiary by a care provider
9 and provides the beneficiary with access to
10 a specialized team, including a hospitalist
11 physician; and
12 "(iii) develops a plan, in consultation
13 with the beneficiary as feasible, that identi-
14 fies goals and objectives with respect to the
15 beneficiary, including measurable outcomes
16 as well as specific services and benefits to
17 be provided.
18 "(e) PAYMENTS.—
19 "(1) IN GENERAL.—For each individual en-
20 rolled with a participating organization under the
21 program, the Secretary shall make a monthly
22 capitated payment to the organization in the same
23 manner as such a payment would be made under
24 part C for an individual enrolled in an MA-plan

1 (that was not an MA–PD plan) offered by a Medi-
2 care Advantage organization, except that—
3 ‘‘(A) notwithstanding section 1853, the
4 amount of the payment shall be determined,
5 subject to subparagraph (B), in an amount
6 equivalent to 98 percent of the projected cost,
7 under the Medicare fee-for-service program
8 under parts A and B for the highest cost Medi-
9 care fee-for-service beneficiaries; and
10 ‘‘(B) the amount of such payment shall be
11 adjusted, in a manner specified by the Sec-
12 retary, to take into account differences in costs
13 among different geographic areas and among
14 high cost Medicare fee-for-service beneficiaries
15 (including outlier costs for the most costly such
16 beneficiaries).
17 ‘‘(2) PROJECTION BASED UPON HISTORICAL
18 DATA.—In applying paragraph (1)(A), the Secretary
19 shall use historical fee-for-service spending and en-
20 rollment data for the highest cost Medicare fee-for-
21 service beneficiaries, trended forward to the first
22 year of the program, and, for subsequent years of
23 the program, increased by projected growth in such
24 spending for such beneficiaries.

1 "(3) RELATIONSHIP TO PAYMENT FOR COV-
2 ERED PART D DRUGS.—In the case of an individual
3 who is enrolled with a participating organization
4 under the program—
5 "(A) if the individual is enrolled with a
6 prescription drug plan under part D, payment
7 for covered part D drugs for such individual is
8 made under such prescription drug plan under
9 such part and not under the program; and
10 "(B) if the individual is covered under a
11 qualified retiree prescription drug plan under
12 section 1860D–22, payment for covered part D
13 drugs for such individual is made under such
14 plan and not under the program.
15 "(f) EVALUATION AND REPORT TO CONGRESS.—
16 "(1) EVALUATION.—The Secretary shall con-
17 duct an independent evaluation of the program.
18 Such evaluation shall include an analysis of the im-
19 pact of the program on coordination of care, expend-
20 itures by participating organizations and plans, the
21 program's impact on reducing expenditures under
22 this title, beneficiary access to services and pro-
23 viders, the quality of health care services furnished
24 to beneficiaries, and beneficiary experiences with

1 auto-enrollment and disenrollment under the pro-
2 gram.

3 "(2) REPORT.—Not later than 2 years after the
4 date that Medicare beneficiaries are first enrolled
5 under the program, the Secretary shall submit to
6 Congress a report on the performance of the pro-
7 gram. Such report shall include the results of the
8 evaluation conducted under paragraph (1) and the
9 program's impact on reducing expenditures under
10 this title and on improving the quality of care for
11 the highest cost Medicare fee-for-service beneficiaries
12 enrolled under the program.

13 "(g) DEFINITIONS.—In this section:

14 "(1) HIGHEST COST MEDICARE FEE-FOR-SERV-
15 ICE BENEFICIARY.—The term 'highest cost Medicare
16 fee-for-service beneficiary' means a Medicare fee-for-
17 service beneficiary who has been identified under
18 subsection (c).

19 "(2) MEDICARE FEE-FOR-SERVICE BENE-
20 FICIARY DEFINED.—The term 'Medicare fee-for-
21 service beneficiary' means an individual who—

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

1 "(B) is not enrolled in a Medicare Advan-
2 tage plan under part C.
3 "(3) PROGRAM.—Unless the context indicates
4 otherwise, the term 'program' means the program
5 under this section.
6 "(4) PARTICIPATING ORGANIZATION.—The
7 term 'participating organization' means a selected
8 organization that has entered into a contract to par-
9 ticipate in the program.
10 "(5) SELECTED ORGANIZATION.—The term 'se-
11 lected organization' means a provider-based organi-
12 zation (such as an accountable care organization) or
13 MA organization (as defined for purposes of part C)
14 that the Secretary determines—
15 "(A) meets the requirements to provide
16 services to the highest cost Medicare fee-for-
17 services beneficiaries under the program; and
18 "(B) is accredited by the National Com-
19 mittee for Quality Assurance or otherwise is
20 certified as meeting quality standards.".

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