

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

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,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Program
5 Linking Uncoordinated Services (PLUS) Act”.

1 **SEC. 2. PROGRAM TO IMPROVE CARE FOR HIGHEST COST**
 2 **MEDICARE FEE-FOR-SERVICE BENEFICIA-**
 3 **RIES.**

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

7 “PROGRAM TO IMPROVE CARE FOR HIGHEST COST
 8 MEDICARE FEE-FOR-SERVICE BENEFICIARIES

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

25 “(b) CONDUCT OF PROGRAM.—

26 “(1) PERIOD OF OPERATION AND SCOPE.—

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

8 “(B) EXPANSION AND EXTENSION.—The
9 Secretary may expand the program to addi-
10 tional service areas and extend its duration if
11 the Secretary determines, in consultation with
12 the Chief Actuary of the Centers for Medicare
13 & Medicaid Services, that such expansion and
14 extension will result in additional savings to the
15 Medicare program and will meet the quality
16 performance standards established under sub-
17 section (d)(3)(A)(iii).

18 “(C) RELATION TO PART D.—

19 “(i) IN GENERAL.—The Secretary
20 shall design and implement the program in
21 such manner as to preserve the operation
22 of part D, including payment, noninter-
23 ference, and beneficiary protections under
24 such part.

1 “(ii) COORDINATION MECHANISMS.—

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

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

20 “(c) IDENTIFICATION AND ENROLLMENT OF HIGH-
 21 EST COST MEDICARE FEE-FOR-SERVICE BENE-
 22 FICIARIES.—

23 “(1) IDENTIFICATION.—

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

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

9 “(B) REFINEMENT OF ELIGIBILITY CRI-
10 TERIA.—In identifying highest cost Medicare
11 fee-for-service beneficiaries under this para-
12 graph, the Secretary shall develop such criteria
13 in a manner that eliminates, to the extent prac-
14 ticable, the identification of individuals who oth-
15 erwise appear to meet such criteria only be-
16 cause of a single, isolated high-cost incident,
17 item, or service.

18 “(2) ELIGIBLE BENEFICIARY INITIAL OUT-
19 REACH.—The Secretary shall inform the highest cost
20 Medicare fee-for-service beneficiaries residing in an
21 area covered by the program and provide them with
22 information about the program and the process for
23 enrollment and disenrollment from participating or-
24 ganizations in such area. Such information shall in-
25 clude 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

1 special disenrollment periods described in sec-
 2 tion 1851(e)(4).

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

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

17 “(4) EXTENSION OF CERTAIN GUARANTEED
 18 ISSUANCE RIGHTS TO MEDIGAP COVERAGE IN CASE
 19 OF DISENROLLMENT.—Subparagraph (A) of section
 20 1882(s)(3) shall apply to a Medicare beneficiary en-
 21 rolled with a participating organization under this
 22 section who had previous coverage under a medicare
 23 supplemental insurance policy and who terminates
 24 enrollment with the participating organization in the
 25 same manner as such section applies to an individual

1 described in subparagraph (B)(v) of such section
 2 with respect to enrollment with a health plan, re-
 3 gardless of the time period of participation in the
 4 program and without regard to subparagraph (E)(ii)
 5 of such section.

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

13 “(6) RELATION TO PART D, EMPLOYER-BASED
 14 PRESCRIPTION DRUG COVERAGE, AND MEDICARE
 15 SUPPLEMENTAL COVERAGE.—Except as specifically
 16 provided, nothing in this section shall be construed
 17 as intended to impact benefits or coverage furnished
 18 under a prescription drug plan under part D, under
 19 a group health plan (including under a qualified re-
 20 tiree prescription drug plan as defined in section
 21 1860D–22(a)(2)), or under a medicare supplemental
 22 policy.

23 “(d) PARTICIPATING ORGANIZATION REQUIRE-
 24 MENTS.—

1 “(1) IN GENERAL.—For purposes of partici-
 2 pating in the program, except as provided in this
 3 subsection, a participating organization must meet
 4 the same requirements that apply to a Medicare Ad-
 5 vantage organization and an MA plan that is not an
 6 MA–PD plan under part C, including requirements
 7 relating to—

8 “(A) coverage of items and services under
 9 parts A and B; and

10 “(B) beneficiary protections under part C.

11 “(2) WAIVER AUTHORITY.—Under the pro-
 12 gram, the Secretary may waive the requirements of
 13 this title and title XI but only to the extent nec-
 14 essary to permit participating organizations—

15 “(A) to provide care management, custo-
 16 dial care, transportation, in-home assistance,
 17 and other services that are not otherwise cov-
 18 ered under this title;

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

1 beneficiaries with chronic clinical conditions;
2 and

3 “(C) to maintain provider and pharmacy
4 networks that do not otherwise meet network
5 adequacy standards.

6 “(3) QUALITY AND REPORTING REQUIRE-
7 MENTS.—

8 “(A) IN GENERAL.—Under the program,
9 the Secretary shall—

10 “(i) determine appropriate measures
11 (including, to the extent feasible, outcome
12 measures) to assess the quality of care
13 being provided under the program;

14 “(ii) establish requirements for par-
15 ticipating organizations to report, in a
16 form and manner specified by the Sec-
17 retary, information on such measures;

18 “(iii) establish quality performance
19 standards on such measures to assess the
20 quality of care being provided by such or-
21 ganizations under the program; and

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

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

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

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

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

24 “(4) USE OF INTEGRATED MODEL OF CARE.—

25 The Secretary shall develop care management re-

1 requirements for participating organizations that pro-
 2 vides an integrated care model and that includes the
 3 following elements:

4 “(A) Provision of person-centered, com-
 5 prehensive, and integrated care management
 6 and services.

7 “(B) Provision of services through—

8 “(i) the use of a network of providers
 9 characterized as best-in-class, such as cen-
 10 ters of excellence; and

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

17 “(C) An evidence-based model of care with
 18 appropriate networks of providers and special-
 19 ists.

20 “(D) For each beneficiary enrolled with
 21 the organization under the program, the organi-
 22 zation—

23 “(i) conducts an initial assessment
 24 and an annual reassessment of the bene-
 25 ficiary’s physical, psychosocial, and func-

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

4 “(ii) provides for regular in-person
 5 visits to the beneficiary by a care provider
 6 and provides the beneficiary with access to
 7 a specialized team, including a hospitalist
 8 physician; and

9 “(iii) develops a plan, in consultation
 10 with the beneficiary as feasible, that identi-
 11 fies goals and objectives with respect to the
 12 beneficiary, including measurable outcomes
 13 as well as specific services and benefits to
 14 be provided.

15 “(e) PAYMENTS.—

16 “(1) IN GENERAL.—For each individual en-
 17 rolled with a participating organization under the
 18 program, the Secretary shall make a monthly
 19 capitated payment to the organization in the same
 20 manner as such a payment would be made under
 21 part C for an individual enrolled in an MA-plan
 22 (that was not an MA–PD plan) offered by a Medi-
 23 care Advantage organization, except that—

24 “(A) notwithstanding section 1853, the
 25 amount of the payment shall be determined,

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

6 “(B) the amount of such payment shall be
7 adjusted, in a manner specified by the Sec-
8 retary, to take into account differences in costs
9 among different geographic areas and among
10 high cost Medicare fee-for-service beneficiaries
11 (including outlier costs for the most costly of
12 such beneficiaries).

13 “(2) PROJECTION BASED UPON HISTORICAL
14 DATA.—In applying paragraph (1)(A), the Secretary
15 shall use historical fee-for-service spending and en-
16 rollment data for the highest cost Medicare fee-for-
17 service beneficiaries, trended forward to the first
18 year of the program, and, for subsequent years of
19 the program, increased by projected growth in such
20 spending for such beneficiaries.

21 “(3) RELATIONSHIP TO PAYMENT FOR COV-
22 ERED PART D DRUGS.—In the case of an individual
23 who is enrolled with a participating organization
24 under the program—

1 “(A) if the individual is enrolled with a
2 prescription drug plan under part D, payment
3 for covered part D drugs for such individual is
4 made under such prescription drug plan under
5 such part and not under the program; and

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

11 “(f) EVALUATION AND REPORT TO CONGRESS.—

12 “(1) EVALUATION.—The Secretary shall con-
13 duct an independent evaluation of the program.
14 Such evaluation shall include an analysis of the im-
15 pact of the program on coordination of care, expend-
16 itures by participating organizations and plans, the
17 program’s impact on reducing expenditures under
18 this title, beneficiary access to services and pro-
19 viders, the quality of health care services furnished
20 to beneficiaries, and beneficiary experiences with
21 auto-enrollment and disenrollment under the pro-
22 gram.

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

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

8 “(g) DEFINITIONS.—In this section:

9 “(1) HIGHEST COST MEDICARE FEE-FOR-SERV-
 10 ICE BENEFICIARY.—The term ‘highest cost Medicare
 11 fee-for-service beneficiary’ means a Medicare fee-for-
 12 service beneficiary who has been identified under
 13 subsection (c).

14 “(2) MEDICARE FEE-FOR-SERVICE BENE-
 15 FICIARY DEFINED.—The term ‘Medicare fee-for-
 16 service beneficiary’ means an individual who—

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

21 “(B) is not enrolled in a Medicare Advan-
 22 tage plan under part C.

23 “(3) PROGRAM.—Unless the context indicates
 24 otherwise, the term ‘program’ means the program
 25 under this section.

1 “(4) PARTICIPATING ORGANIZATION.—The
2 term ‘participating organization’ means a selected
3 organization that has entered into a contract to par-
4 ticipate in the program.

5 “(5) SELECTED ORGANIZATION.—The term ‘se-
6 lected organization’ means a provider-based organi-
7 zation (such as an accountable care organization) or
8 MA organization (as defined for purposes of part C)
9 that the Secretary determines—

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

13 “(B) is accredited by the National Com-
14 mittee for Quality Assurance or otherwise is
15 certified as meeting quality standards.”.

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