Revenue Code of 1986 to permit the Secretary of the Treasury to issue prospective guidance clarifying the employment status of individuals for purposes of employment taxes and to prevent retroactive assessments with respect to such clarifications.

S. 1719

At the request of Mrs. MURRAY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 1719, a bill to amend the Public Health Service Act to reauthorize the poison center national toll-free number, national media campaign, and grant program, and for other purposes.

S. 1738

At the request of Mr. CORNYN, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 1738, a bill to provide justice for the victims of trafficking.

S. 1778

At the request of Mr. BURR, the name of the Senator from Missouri (Mr. BLUNT) was added as a cosponsor of S. 1778, a bill to require the Attorney General to report on State law penalties for certain child abusers, and for other purposes.

S. 1798

At the request of Mr. WARNER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1798, a bill to ensure that emergency services volunteers are not counted as full-time employees under the shared responsibility requirements contained in the Patient Protection and Affordable Care Act.

S. 1827

At the request of Ms. MIKULSKI, her name was added as a cosponsor of S. 1827, a bill to award a Congressional Gold Medal to the American Fighter Aces, collectively, in recognition of their heroic military service and defense of our country's freedom throughout the history of aviation warfare.

S. 1844

At the request of Mrs. SHAHEEN, the name of the Senator from West Virginia (Mr. MANCHIN) was added as a cosponsor of S. 1844, a bill to restore full military retirement benefits by closing corporate tax loopholes.

S. 1869

At the request of Ms. AYOTTE, the names of the Senator from Kansas (Mr. MORAN) and the Senator from Arkansas (Mr. BOOZMAN) were added as cosponsors of S. 1869, a bill to repeal section 403 of the Bipartisan Budget Act of 2013, relating to an annual adjustment of retired pay for members of the Armed Forces under the age of 62, and to provide an offset.

S. 1896

At the request of Mr. BROWN, the names of the Senator from Maine (Mr. KING) and the Senator from Oregon (Mr. MERKLEY) were added as cosponsors of S. 1896, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit and provide designated allocations for areas impacted by a decline in manufacturing.

S. 1902

At the request of Mr. BARRASSO, the names of the Senator from New Hampshire (Ms. AYOTTE), the Senator from Arkansas (Mr. BOOZMAN), the Senator from Iowa (Mr. GRASSLEY) and the Senator from North Dakota (Mr. HOEVEN) were added as cosponsors of S. 1902, a bill to require notification of individuals of breaches of personally identifiable information through Exchanges under the Patient Protection and Affordable Care Act.

S. 1908

At the request of Mr. CORNYN, the names of the Senator from Georgia (Mr. ISAKSON) and the Senator from Florida (Mr. RUBIO) were added as cosponsors of S. 1908, a bill to allow reciprocity for the carrying of certain concealed firearms.

S. 1909

At the request of Mr. SCOTT, the name of the Senator from Kentucky (Mr. MCCONNELL) was added as a cosponsor of S. 1909, a bill to expand opportunity through greater choice in education, and for other purposes.

S. 1919

At the request of Mr. PAUL, the name of the Senator from Texas (Mr. CRUZ) was added as a cosponsor of S. 1919, a bill to repeal the Authorization for Use of Military Force Against Iraq Resolution of 2002.

S. RES. 323

At the request of Mr. CHAMBLISS, the name of the Senator from Arkansas (Mr. BOOZMAN) was added as a cosponsor of S. Res. 323, a resolution expressing the sense of the Senate on maintaining the current annual adjustment in retired pay for members of the Armed Forces under the age of 62.

S. RES. 330

At the request of Mr. BLUMENTHAL, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Res. 330, a resolution recognizing the 50th anniversary of ''Smoking and Health: Report of the Advisory Committee to the Surgeon General of the United States'' and the significant progress in reducing the public health burden of tobacco use, and supporting an end to tobacco-related death and disease.

STATEMENT ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN (for himself and Mr. ISAKSON):

S. 1932. A bill to amend title XVIII of the Social Security Act to establish a Medicare Better Care Program to provide integrated care for Medicare beneficiaries with chronic conditions, and for other purposes; to the Committee on Finance.

Mr. WYDEN. Mr. President, I rise today to show my strong support for the Medicare Program with the introduction of the Better Care, Lower Cost Act with my colleague, Senator ISAKSON.

The Medicare Program, treasured by millions of Americans today, is now dominated by cancer, diabetes, heart disease, and other chronic conditions. It is time for reform that offers seniors with chronic health challenges better quality, more affordable health care.

Fortunately, there are several pioneering health care leaders already paving the way to reform. The bipartisan legislation we are offering is designed to remove the government's shackles on innovation so that the types of successful approaches discussed by health care leaders here this morning become the norm rather than the exception.

The good news is that when the Senate Finance Committee recently approved legislation to fix Medicare's broken system of reimbursing doctors, the bill locked in specific incentives to move away from fee-for-service medicine. As part of its markup, the Senate Finance Committee added the foundation for improving chronic care for seniors: reforms that guarantee many more seniors access to individual care plans tailored to their unique needs.

The Better Care, Lower Cost Act builds on that progress and introduces a bold new concept in Medicare: the idea that chronic care should come first. Here are a few things the legislation does to promote this idea:

First, the legislation creates the Better Care Program, allowing health practices to create better care practices and health plans to become better health plans that care for patients with teams led by nurses, doctors, and physician assistants that must adhere to the highest quality standards. These innovators will receive one payment for their collective efforts to meet the chronic health needs of the seniors enrolled. This will give providers the flexibility to deliver the right care at the right time in the right place.

Second, because most seniors lack access to coordinated, chronic care services today, the legislation sets aside the limiting Federal mandates—like the ''attribution rule''—that prevent these teams from actively reaching out to the seniors who would benefit most from specialized chronic care. Our legislation also changes Federal law so that participating practices and plans are able to reward seniors who participate in the Better Care Program by lowering their out-of-pocket costs when they work with their health care team.

Third, this bill recognizes that seniors with chronic conditions live all over the country and sets out a plan for bringing providers and plans to every nook and cranny of America. And for those seniors and providers in rural or underserved areas, the legislation uses telemedicine and other technologies as resources to help to closely monitor and manage chronic conditions.

Finally, a word about the private sector. This bill recognizes the advances that have been made that prove that better care can be provided at lower cost. There should not be as many barriers when arriving at the gates of Medicare. In fact, in my hometown of Portland, OR, when seniors talk about their Medicare, they are really talking about plans like Kaiser and Providence that are fully integrated. Seniors should have those care choices no matter where they live.

In Washington, there is talk a lot about ''Medicare delivery system reform'' without mentioning why it is necessary or how it will actually help the people Medicare serves. The legislation Senator Isakson and I are introducing today is about giving seniors with chronic illnesses the focus and attention they need and deserve.

Every day Americans hear new statistics about the impact chronic illness has on families, productivity, and the economy as a whole. But I can't recall a legislative effort where all those involved have remained singularly focused on solutions to this big problem.

To be clear, this legislation is not driven by a simple desire to cut costs. Anyone can save money by cutting benefits, but this legislation would actually improve the care that seniors receive. I urge my colleagues to join us in this effort by cosponsoring this important legislation.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1932

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Better Care, Lower Cost Act''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Medicare Better Care Program.
Sec. 4. Chronic special needs plans.
Sec. 5. Improvements to welcome to Medicare visit and annual wellness visits.
Sec. 6. Chronic care innovation centers.
Sec. 7. Curricula requirements for direct and indirect graduate medical education payments.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The field of medicine is ever-evolving and we need a highly skilled, team-oriented workforce that can meet the health care needs of today as well as the health care challenges of tomorrow.

(2) The Medicare program should recognize the growing uses and benefits of health technology in delivering quality and cost-efficient care by encouraging the use of telemedicine and remote patient monitoring.

SEC. 3. MEDICARE BETTER CARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''MEDICARE BETTER CARE PROGRAM

''SEC. 1899B. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2017, the Secretary shall establish an integrated chronic care delivery program (in this section referred to as the 'program') that promotes accountability and better care management for chronically ill patient populations and coordinates items and services under parts A, B, and D, while encouraging investment in infrastructure and redesigned care processes that result in high quality and efficient service delivery for the most vulnerable and costly populations. The program shall—

''(A) focus on long-term cost containment and better overall health of the Medicare population by implementing through qualified BCPs (as described in paragraph (2)(A)) strategies that prevent, delay, or minimize the progression of illness or disability associated with chronic conditions; and

''(B) include the program elements described in paragraph (2).

''(2) PROGRAM ELEMENTS.—The following program elements are described in this paragraph:

''(A) A health plan or group of providers of services and suppliers, or a health plan working with such a group, that the Secretary certifies in accordance with subsection (e) as meeting criteria developed by the Secretary to recognize the challenges of managing a chronically ill population, including patient satisfaction and engagement, quality measurement developed specifically for a chronically ill population, and effective use of resources and providers, may manage and coordinate care for BCP eligible individuals through an integrated care network, or Better Care Program (referred to in this section as a 'qualified BCP'). A group of providers of services and suppliers described in the preceding sentence may also be participating in another alternative payment model (as defined in subsection (k)).

''(B) Payments to a qualified BCP shall be made in accordance with subsection (g).

''(C) Implementation of the program shall focus on physical, behavioral, and psychosocial needs of BCP eligible individuals.

''(D) Quality and cost containment are considered interdependent goals of the program.

''(E) The calculation of long-term cost savings is dependent on qualified BCPs delivering the full continuum of covered primary, post-acute care, and social services using capitated financing.

''(3) TARGETED PARTICIPATION.—

''(A) IN GENERAL.—In certifying qualified BCPs throughout the country, the Secretary shall give priority to areas—

''(i) that do not have a concentration of accountable care organizations under section 1899; and

''(ii) with a high burden of chronic conditions.

''(B) INITIAL REQUIREMENT.—In the first 5 years of the program, at least 50 percent of all new qualified BCPs certified nationwide by the Secretary shall be from counties or regions, as determined by the Secretary, where the prevalence of the most costly chronic conditions is at or greater than 125 percent of the national average.

''(C) RESTRICTING THE NUMBER OF PARTICIPATING BCPS.—

''(i) IN GENERAL.—The Secretary shall take into account geography, urban and rural designations, and the population case mix that will be served, when selecting BCPs for participation.

''(ii) LIMITATION DURING THE FIRST FOUR PROGRAM YEARS.—During the first four years of the program, the total number of qualified BCPs certified by the Secretary shall not exceed 250.

''(iii) NO LIMITATION DURING FIFTH AND SUBSEQUENT PROGRAM YEARS.—During the fifth year and any subsequent year of the program, the Secretary may certify any BCP that meets the requirements to be certified as a qualified BCP.

''(4) ALIGNMENT WITH APPROVED STATE PLAN WAIVERS.—In certifying qualified BCPs, the Secretary shall ensure alignment with other approved waivers of State plans under title XIX.

''(b) DEFINITION OF BCP ELIGIBLE INDIVIDUALS.—

''(1) DEFINITION.—For purposes of this section, the term 'BCP eligible individual' means an individual who—

''(A) is entitled to benefits under part A and enrolled under parts B and D, including an individual who is enrolled in a Medicare Advantage plan under part C, an eligible organization under section 1876, or a PACE program under section 1894; and

''(B) is medically complex given the prevalence of chronic disease that actively and persistently affects their health status, and absent appropriate care interventions, causes them to be at enhanced risk for hospitalization, limitations on activities of daily living, or other significant health outcomes.

''(2) DUAL ELIGIBLE INDIVIDUALS.—An individual who is dually eligible for Medicare and Medicaid shall not be excluded from enrolling in a qualified BCP. Dually eligible beneficiaries enrolled in a qualified BCP will see the full scope of their benefits under this title and title XIX (other than long-term care) managed by the qualified BCP.

''(c) NOTIFICATION AND ENROLLMENT.—

''(1) NOTIFICATION.—Not later than October 1 of each year, the Secretary shall use all available tools, including the notice mailed annually under section 1804(a) and State health insurance assistance programs, to notify BCP eligible individuals of qualified BCPs in their area for the upcoming plan year. Such information shall also be easily accessible on the Internet website of the Centers for Medicare & Medicaid Services.

''(2) ENROLLMENT.—The Secretary shall establish procedures under which BCP eligible individuals may voluntarily enroll in a qualified BCP at the following times:

''(A) During the annual, coordinated election period under section 1851(e)(3)(B).

''(B) During or following (for a length of time determined by the Secretary)—

''(i) an initial preventive physical examination (as defined in section 1861(ww)); or

''(ii) any subsequent visit where a chronic condition is identified or a previous condition is identified as having escalated to the level of a chronic condition.

''(d) PATIENT ASSESSMENT.—

''(1) STANDARDIZED FUNCTIONAL AND HEALTH RISK ASSESSMENT.—

''(A) MINIMUM GUIDELINES.—Not later than January 1, 2016, the Secretary shall publish minimum guidelines for qualified BCPs to furnish to enrollees a health information technology-compatible, standardized, and multidimensional risk assessment that—

''(i) assesses and quantifies the medical, psychosocial, and functional status of an enrollee; and

''(ii) includes a mechanism to determine the level of patient activation and ability to engage in self-care of an enrollee.

''(B) UPDATING.—Not less frequently than once every 3 years, the Secretary shall, through rulemaking, update such minimum guidelines to reflect new clinical standards and practices, as appropriate.

''(2) INDIVIDUAL PATIENT-CENTERED CHRONIC CARE PLAN.—

''(A) MODEL PLAN.—Not later than January 1, 2016, the Secretary shall publish minimum guidelines for qualified BCPs to develop individual patient-centered chronic care plans for enrollees. Such a plan shall—

''(i) allow health professionals to incorporate the medical, psychosocial, and functional components identified in the risk assessment described in paragraph (1)(A)(i);

''(ii) provide a framework that can be easily integrated into electronic health records, allowing clinicians to make timely, accurate, evidence-based decisions at the point of care; and

''(iii) allow for the provider to describe how services will be provided to the enrollee.

''(B) USE OF TECHNOLOGY FOR PATIENT SELF CARE.—

''(i) IN GENERAL.—Whenever appropriate, the individual patient-centered chronic care plan of an enrollee shall include the use of technologies that enhance communication between patients, providers, and communities of care, such as telehealth, remote patient monitoring, Smartphone applications, and other such enabling technologies, that promote patient engagement and self care while maintaining patient safety.

''(ii) COORDINATION AND DEVELOPMENT OF STREAMLINED PATHWAY.—The Secretary shall work with the Office of the National Coordinator for Health Information Technology and the Department of Health and Human Services Chief Technology Officer to develop a streamlined pathway for the use of mobile applications and communications devices that effectively enhance the experience of the patient while maintaining patient safety and cost-effectiveness. Such pathway shall not duplicate existing efforts.

''(e) QUALIFIED BCP PROVIDERS.—

''(1) CRITERIA.—

''(A) IN GENERAL.—Any health plan, provider of services, or group of providers of services and suppliers, who agrees to meet the requirements described in paragraph (2) and is specified in subparagraph (C) may form a multidisciplinary team of health professionals to be certified as a qualified BCP. Those providers may also choose to partner with a qualified insurer to become a qualified BCP.

''(B) NO PREEMPTION OF STATE LICENSURE LAWS.—Nothing in this section shall preempt State licensure laws.

''(C) GROUPS OF PROVIDERS AND SUPPLIERS SPECIFIED.—

''(i) IN GENERAL.—As determined appropriate by the Secretary, the following health plans, providers of services, or groups of providers of services and suppliers, that meet the criteria described in clause (ii) may be certified as qualified BCPs under the program:

''(I) Health professionals acting as part of a multidisciplinary team.

''(II) Networks of individual practices of health professionals that may include community health centers, Federally qualified health centers, rural health clinics, and partnerships or affiliations with hospitals.

''(III) Health plans that meet appropriate network adequacy standards, as determined by the Secretary, and that include providers with experience and interest in managing a population with chronic conditions.

''(IV) Independent health professionals partnering with an independent risk manager.

''(V) Such other groups of providers of services or suppliers as the Secretary determines appropriate.

''(ii) CRITERIA DESCRIBED.—The following criteria are described in this clause:

''(I) Demonstrated capacity to manage the full continuum of care (other than long-term care) for the specialized population of BCP eligible individuals.

''(II) Having a high rate of Medicare customer satisfaction, when applicable, or partnering with providers of services or suppliers with such a demonstrated high satisfaction rate.

''(2) REQUIREMENTS.—A qualified BCP shall meet the following requirements:

''(A) The qualified BCP shall be accountable for the quality, cost, and overall care of enrolled BCP eligible individuals and agree to be at financial risk for that enrolled population. A qualified BCP shall be established with the objective of serving BCP eligible individuals.

''(B) The qualified BCP shall be responsible for the full continuum of care (other than long-term care) for enrollees. This continuum shall include medical care, skilled nursing and home health services, behavioral health care, and social services. The qualified BCP may not actively restrict an enrollee's access to providers based on a practitioner's license or medical specialty based on cost alone.

''(C) The qualified BCP shall primarily consist of a care team tasked with responding to, treating, and actively supporting the needs of BCP eligible individuals. The care team shall also develop a care plan for each eligible BCP enrollee and use it as a tool to execute effective care management and transitions.

''(D) The qualified BCP shall include physicians, nurse practitioners, registered nurses, social workers, pharmacists, and behavioral health providers who commit to caring for BCP eligible individuals.

''(E) The qualified BCP shall enter into an agreement with the Secretary to participate in the program under this section for not less than a 3-year period.

''(F) The qualified BCP shall include adequate numbers of primary care and other relevant professionals that can effectively care for the number of BCP eligible individuals enrolled in the qualified BCP.

''(G) The qualified BCP shall provide the Secretary with such information regarding qualified BCP professionals participating in the qualified BCP necessary to support the enrollment of BCP eligible individuals in a qualified BCP, including evidence relating to high patient satisfaction when available, the implementation of quality reporting and other reporting requirements, and evidence to support a determination of capitated payments in accordance with subsection (g).

''(H) The qualified BCP shall have in place a structure that includes clinical and administrative systems, including health information technology, that supports the integration of services and providers across sites of care.

''(I) The qualified BCP may develop a collaborative partnership that supports the mission of the BCP with each of the following:

''(i) A regional or national Chronic Care Innovation Center under section 6 of the Better Care, Lower Cost Act.

''(ii) A regional or national Center of Innovation (COIN) of the Department of Veterans Affairs Health Services Research and Development Service to identify and implement best practices—

''(I) to increase access to, and implementation of, prevention and wellness tools;

''(II) to integrate physical and behavior health care with social services;

''(III) to promote evidence-based medicine and patient engagement;

''(IV) to coordinate care across providers and care settings;

''(V) to allow more patients to be cared for in their homes and communities;

''(VI) to reduce hospital readmissions;

''(VII) to improve health outcomes for patients with chronic conditions; and

''(VIII) to report on quality improvement and cost measures.

''(iii) A regional or national Telehealth Resource Center of the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth to create an interactive, online resource for qualified BCP professionals who may need additional training or assistance in managing the needs of a complex patient population, including—

''(I) continuing training and education and mentoring for qualified BCP professionals at any level of licensure;

''(II) clinician support for complex patients by an expert panel;

''(III) remote access to regional, national, and international experts in the field;

''(IV) forums for best practices to be discussed among qualified BCP professionals;

''(V) inter-professional education supporting optimal communication between members of a chronic care team; and

''(VI) continuing training on the use of telehealth, remote patient monitoring, and other such enabling technologies.

''(J) The qualified BCP shall demonstrate to the Secretary that it meets person-centeredness criteria specified by the Secretary in collaboration with accreditation organizations, including the use of patient and caregiver assessments and the use of individual patient-centered chronic care plans for each enrollee (as described in subsection (d)(2)).

''(K) The qualified BCP may identify and respond to unique cultural, social, and economic needs of a community that impact access to, and quality of, healthcare.

''(L) The qualified BCP shall provide care across settings, including in the home as needed.

''(M) The qualified BCP shall demonstrate financial solvency (as determined by the Secretary).

''(N) The qualified BCP shall demonstrate the ability to partner with providers of social and behavioral health services within the community.

''(O) The qualified BCP shall engage in continuing education on chronic care, on an ongoing basis (as determined necessary by the Chronic Care Innovation Center under the partnership under subparagraph (J)(i)), in collaboration with the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Department of Veterans Affairs.

''(f) IMPLEMENTING VALUE-BASED INSURANCE DESIGN.—

''(1) IN GENERAL.—

''(A) ELECTION.—A qualified BCP may elect to provide value-based Medicare coverage in accordance with this subsection.

''(B) INCLUSION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM BENEFITS.—Subject to subparagraph (C), enrollees in a qualified BCP that elects to provide value-based Medicare coverage under this subsection shall receive such coverage that includes items and services for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those items and services as described in subparagraph (C).

''(C) COST SHARING.—Cost-sharing described in this subparagraph, with respect to an enrollee in a qualified BCP that makes such an election, is varied cost-sharing approved by the Secretary to incentivize the use of high-value, high-quality services that have been clinically proven to benefit BCP eligible individuals.

''(D) CHANGES IN COVERAGE.—The Secretary, in consultation with experts in the field, shall establish a process for qualified BCPs to submit value-based Medicare coverage changes that encourage and incentivize the use of evidence-based practices that will drive better outcomes while ensuring patient protections and access are maintained.

''(E) NO REQUIREMENT FOR COVERAGE OF LONG-TERM CARE SERVICES.—In no case shall

a qualified BCP be required to provide to enrollees coverage for long-term care services.

''(2) QUALIFIED BCP PARTICIPATION.—

''(A) CONTINUED ACCESS.—Subject to subparagraph (B), enrollees in a qualified BCP shall continue to have access to all providers of services and suppliers under this title.

''(B) NO APPLICATION OF VARIED COST-SHARING FOR NONPARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

''(i) IN GENERAL.—The varied cost-sharing under paragraph (1)(B) shall only apply to items and services furnished by qualified BCP professionals of a qualified BCP that makes an election under paragraph (1). In the case where items and services are furnished by a provider of services or supplier who is not such a qualified BCP professional, the cost-sharing applicable for those items and services will be the cost-sharing as required under parts A and B, or an actuarially equivalent level of cost-sharing as determined by the Secretary.

''(ii) NOTIFICATION.—A BCP eligible individual shall be notified and counseled prior to the time of enrollment on potential changes in out-of-pocket costs that may occur if care is provided by a provider of services or supplier that is not a qualified BCP professional.

''(3) LIMITATIONS ON OUT-OF-POCKET EXPENSES OUTSIDE A QUALIFIED BCP.—

''(A) IN GENERAL.—Out-of-pocket costs, including individual beneficiary copayments, with respect to items and services furnished by a provider of services or supplier who is not a qualified BCP professional shall not exceed what would otherwise have been paid with respect to the item or service under the original Medicare fee-for-service program under parts A and B for the same services or an actuarially equivalent level of cost-sharing as determined by the Secretary, or, in the case of a dual eligible individual, under the Medicaid program under title XIX.

''(B) PROHIBITION ON COVERAGE OF COST-SHARING FOR CERTAIN ITEMS AND SERVICES FURNISHED TO AN ENROLLEE OUTSIDE OF A QUALIFIED BCP UNDER MEDIGAP POLICIES.—For provisions relating to prohibition on coverage of cost-sharing for items and services (other than emergent services, as defined by the Secretary) furnished to an enrollee outside of a qualified BCP under medigap policies, see section 1882(z).

''(4) PRESCRIPTION DRUG COVERAGE.—

''(A) DRUG PLAN OPTION.—

''(i) IN GENERAL.—A health plan certified as a qualified BCP may provide enrollees with a drug plan option specifically designed to reflect the medication needs of enrollees.

''(ii) APPLICATION OF PART D PROVISIONS.—

''(I) IN GENERAL.—Except as otherwise provided in this section, the provisions of part D shall apply to a drug plan option offered by a qualified BCP under clause (i) in the same manner as such provisions apply to a prescription drug plan offered by a PDP sponsor under such part.

''(II) LIMITATION OF ENROLLMENT.—A qualified BCP offering such a drug plan option may limit enrollment in the drug plan option to enrollees in the qualified BCP.

''(III) WAIVER.—The Secretary may waive such provisions of part D as are necessary to carry out this section.

''(B) AGREEMENT WITH PRESCRIPTION DRUG PLANS.—A qualified BCP managed by a group of providers of services may enter into an agreement with a PDP sponsor of a prescription drug plan under part D to establish and encourage individuals enrolled in the qualified BCP to enroll in a prescription drug plan under such part that is better suited to the needs of chronically ill individuals.

''(C) LIMITATION.—A drug plan option offered by a qualified BCP under subparagraph (A)(i) shall not have the authority to increase out-of-pocket limits otherwise applicable under part D.

''(g) PAYMENTS AND TREATMENT OF SAVINGS.—

''(1) PAYMENTS TO QUALIFIED BCPS ON A CAPITATED BASIS.—

''(A) IN GENERAL.—In the case of a qualified BCP under this section, the Secretary shall make prospective monthly payments of a capitation amount for each BCP eligible individual enrolled in the qualified BCP in the same manner and from the same sources as payments are made to a Medicare Advantage organization under section 1853. Such payments shall be subject to adjustment in the manner described in section 1853(a)(2) or section 1876(a)(1)(E), as the case may be.

''(B) CAPITATION AMOUNT.—The capitation amount to be applied under this paragraph for a qualified BCP for each enrollee for a year shall be 1/12 of the benchmark rate under subparagraph (C)(ii) for the year (or the relevant rate under subparagraph (C)(i) for the first year of the program under this section) (referred to in this paragraph as the 'per member per month payment'), as adjusted under clause (iii).

''(C) DETERMINING THE RATE USING RISK RELEVANT CONTROL GROUP.—

''(i) RELEVANT RATE.—

''(I) IDENTIFICATION OF BENEFICIARY GROUPING.—Using claims data, the Secretary shall identify a group of beneficiaries who have similar health risk characteristics, and have sought care in the same county, multi-county, or State level (as determined appropriate by the Secretary to establish a payment area) to the population the qualified BCP is tasked with serving. To the extent feasible for a statistically valid control group, the health risk of such group shall reflect social characteristics, such as income, as well as medical risk.

''(II) DETERMINATION OF RELEVANT RATE.—The per capita spending amounts under this title and, as appropriate, title XIX, of the group of beneficiaries identified under subclause (I) shall determine the 'relevant rate' that will serve as the basis of the benchmark for participating qualified BCPs.

''(ii) BENCHMARK RATE.—The Secretary shall establish the benchmark rate for a qualified BCP service area for each year of the program by updating the relevant rate determined under clause (i) with the projected change in per capita spending for the group of beneficiaries identified under clause (i)(I) for the payment area described in such clause, as determined by the Chief Actuary of the Centers for Medicare & Medicaid Services.

''(iii) ADJUSTMENT FOR HEALTH STATUS.—

''(I) COMPARISON OF HEALTH STATUS.—The Secretary shall establish a risk score mechanism to compare the health status of an enrollee in a qualified BCP to the average health risk of group of beneficiaries identified under clause (i)(I).

''(II) INCLUSION OF NUMBER OF CONDITIONS.—The Secretary shall provide that a risk score under the mechanism under this clause, with respect to an individual, includes an indicator for the number of chronic conditions with which the individual has been diagnosed.

''(III) USE OF 2 YEARS OF DIAGNOSIS DATA.—The Secretary shall ensure that such risk score, with respect to an individual reflects not less than 2 years of diagnosis data, to the extent available.

''(IV) ADJUSTMENT FOR HEALTH STATUS.—The per member per month payment to the qualified BCP for each enrollee shall be adjusted depending on how the individual risk profile of the enrollee compares to the average health status of such group of beneficiaries. If an enrollee has a risk profile that is not as severe as the average health status of such group of beneficiaries, then the per member per month shall be decreased to reflect the 'healthier' status of the enrollee. If an enrollee has a risk profile that is more severe, then the per member per month payment to the qualified BCP shall be increased to reflect the more acutely ill status of the enrollee.

''(D) SHARED RISK PAYMENTS FOR CERTAIN QUALIFIED BCPS DURING FIRST 3 YEARS OF THE PROGRAM.—

''(i) IN GENERAL.—This subparagraph shall only apply to qualified BCPs offered by a group of providers of services and suppliers during the first 3 years of the program under this section.

''(ii) SHARING OF RISK TO ALLEVIATE OUTLIERS.—The Secretary shall determine shared risk payments and recoupments under this subparagraph for a qualified BCP described in clause (i) as follows:

''(I) DETERMINATION OF GAIN OR LOSS.—The Secretary shall, for each of the first 3 years of the program under this section, determine the percentage of gain or loss for the qualified BCP in providing benefits to enrollees under this section.

''(II) GAIN OR LOSS GREATER THAN 5 PERCENT.—If the Secretary determines the qualified BCP has a gain or loss for the year of greater than 5 percent, the qualified BCP shall bear 100 percent of the risk or reward of such loss or gain.

''(III) GAIN OR LOSS OF NOT LESS THAN 2 AND NOT GREATER THAN 5 PERCENT.—If the Secretary determines the qualified BCP has a gain or loss for the year of not less than 2 percent but not greater than 5 percent—

''(aa) the qualified BCP shall bear 80 percent of the risk or reward, as applicable, of such loss or gain; and

''(bb) the Secretary shall bear 20 percent of the risk or reward, as applicable, of such loss or gain.

''(IV) GAIN OR LOSS BETWEEN 0 AND 2 PERCENT.—If the Secretary determines the qualified BCP has a gain or loss for the year of greater than 0 percent but less than 2 percent—

''(aa) the qualified BCP shall bear 50 percent of the risk or reward, as applicable, of such loss or gain; and

''(bb) the Secretary shall bear 50 percent of the risk or reward, as applicable, of such loss or gain.

''(iii) PROVISION OF INFORMATION.—A qualified BCP shall provide to the Secretary such information as the Secretary determines is necessary to carry out this subparagraph.

''(E) BID SUBMISSION.—Beginning with the fourth year of the program, a qualified BCP shall submit a bid for participation in the program for the year that reflects the experience of the qualified BCP—

''(i) in managing the care of the enrolled population; and

''(ii) in managing such care given the relevant rate determined under subparagraph (C).

''(F) QUALITY BONUS SYSTEM.—

''(i) IN GENERAL.—The Secretary shall establish a quality bonus system whereby the Secretary distributes bonus payments to qualified BCPs that meet the requirements described in clause (iii) and other standards specified by the Secretary, which may include a focus on quality measurement and improvement, delivering patient-centered care, and practicing in integrated health systems, including training in community-based settings. In developing such standards, the Secretary shall collaborate with relevant stakeholders, including program accrediting bodies, certifying boards, training programs, health care organizations, health care purchasers, and patient and consumer groups.

''(ii) DETERMINATION OF QUALITY BONUSES.—Quality bonuses to the BCP shall be based on

a comparison of the quality of care provided by the qualified BCP to enrollees to the quality of care provided to beneficiaries not enrolled in a qualified BCP or a Medicare Advantage plan under part C in the same region. For not less than the first 5 years of the program under this section, quality measures for the geographic region shall be based on local standards of care, and not on a national standard. For subsequent years, appropriate national standards shall be considered for inclusion in the comparison of the quality of care under this subparagraph.

''(iii) REQUIREMENTS.—A qualified BCP is eligible for quality bonuses under this subparagraph if—

''(I) the qualified BCP meets quality performance standards under subsection (h)(3); and

''(II) the qualified BCP meets the requirements under subsection (e)(2).

''(h) QUALITY AND OTHER REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall develop and implement, with assistance and input of relevant experts in the field and the National Strategy for Quality Improvement in Health Care, appropriate measures for BCP eligible individuals. The Secretary shall determine appropriate measures under this title and title XIX to assess the quality of care furnished by a qualified BCP, as well as those measures that are no longer appropriate and shall be removed from use. Such measures shall include measures—

''(A) of clinical processes and outcomes;

''(B) of patient and, where practicable, caregiver experience of care, including measurement that enhances patient activation and engagement;

''(C) of utilization (such as rates of hospital admissions for ambulatory care sensitive conditions);

''(D) of care coordination, management, and transitions; and

''(E) that appropriately align with the National Strategy for Quality Improvement in Health Care.

The Secretary may use existing measures under this title, title XIX, or any other health care program, as appropriate, under this paragraph.

''(2) REPORTING REQUIREMENTS.—A qualified BCP shall submit data in a form and manner specified by the Secretary which is not overly burdensome to the qualified BCP, on measures the Secretary determines necessary for the qualified BCP to report in order to evaluate the quality of care furnished by the qualified BCP. Such data reporting shall emphasize 'patient-centered measurement' and may include the functional status of patients, case management and care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by qualified BCP professionals, as the Secretary determines appropriate.

''(3) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by qualified BCPs. The Secretary shall seek to improve the quality of care furnished by qualified BCPs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care. The Secretary shall also include a process for retiring measures that are no longer adequately contributing to improving standards of care at the greatest possible value.

''(4) OTHER REPORTING REQUIREMENTS AND CALL FOR ALIGNMENT.—The Secretary shall, as the Secretary determines appropriate, incorporate and align reporting requirements and incentive payments related to the physician quality reporting system under section 1848, including those related to reporting on quality measures under subsection (m) of that section, reporting requirements under subsection (o) of that section relating to meaningful use of electronic health records, the establishment of a value-based payment modifier under subsection (p) of that section, and other similar initiatives under that section, and may use alternative criteria than would otherwise apply under section 1848 for determining whether to make such payments to qualified BCP professionals. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (g).

''(i) BENEFICIARY PROTECTIONS.—The Secretary shall ensure that, to the extent consistent with this section, a qualified BCP offers beneficiary protections applicable to beneficiaries under this title and, as applicable, title XIX.

''(j) PAYMENT OF MEDICARE COST-SHARING FOR DUAL ELIGIBLE INDIVIDUALS.—In the case of a dual eligible individual enrolled in a qualified BCP, the Secretary may provide for the payment of medicare cost-sharing (as defined in section 1905(p)(3)) that would otherwise be available under the State plan under title XIX if the individual was not enrolled in the qualified BCP.

''(k) DEFINITIONS.—In this section:

''(1) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means any of the following:

''(A) A model under section 1115A (other than a health care innovation award).

''(B) An accountable care organization under section 1899.

''(C) A demonstration under section 1866C.

''(D) A demonstration required by Federal law.

''(E) A qualified BCP.

''(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(3) QUALIFIED BCP PROFESSIONAL.—The term 'qualified BCP professional' means a certified and licensed professional of medical or behavioral health services that is participating in a qualified BCP.''.

(b) FEDERAL ASSUMPTION OF MEDICAID COSTS FOR FULL BENEFIT DUAL ELIGIBLE INDIVIDUALS ENROLLED IN A QUALIFIED BCP.—Title XIX of the Social Security Act is amended by inserting after section 1943 the following new section:

''FEDERAL ASSUMPTION OF MEDICAID COSTS FOR FULL BENEFIT ELIGIBLE INDIVIDUALS ENROLLED IN A QUALIFIED BCP

''SEC. 1944. (a) STATE CONTRIBUTION.—

''(1) IN GENERAL.—The State shall provide for payment to the Secretary for each month in an amount determined under paragraph (2)(A) for each applicable dual eligible BCP enrollee for such State.

''(2) STATE CONTRIBUTION AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (C), the amount determined under this paragraph for a State for a month in a year is equal to the product described in subparagraph (A) of section 1935(c)(1) for the State for the month, except that the reference in such subparagraph to the total number of full-benefit dual eligible individuals shall be deemed a reference to the total number of applicable dual eligible BCP enrollees.

''(B) FORM AND MANNER OF PAYMENT.—The provisions of subparagraphs (B) through (D) of section 1935(c)(1) shall apply to payment by a State to the Secretary under this paragraph in the same manner as such subparagraphs apply to payment under section 1935(c)(1)(A).

''(C) APPLICATION OF DIFFERENT FACTORS.—In applying subparagraph (A), the following shall be substituted under paragraphs (2) and (3) of section 1935(c):

''(i) The base year State Medicaid per capita expenditures for covered part D drugs described in subparagraph (A)(i)(I) of such paragraph (2) shall be deemed to be the per capita expenditures for health care items and services that would apply (including any medicare cost-sharing), with respect to an applicable dual eligible BCP enrollee, if such an individual received benefits only under title XVIII (and not the State plan under this title).

''(ii) Any reference to expenditures for covered part D drugs or for prescription drug benefits shall be deemed a reference to the expenditures for health care items and services described in clause (i).

''(iii) Any reference to 2003 or 2004 shall be deemed a reference to 2017 or 2018, respectively.

''(iv) Any reference to a full-benefit-dual-eligible individual shall be deemed a reference to an applicable dual eligible BCP enrollee.

''(v) The applicable growth factor under section 1935(c)(4) for a year, with respect to a State, shall be the average annual percentage change (to that year from the previous year) of the expenditures of the State under the State plan under title XIX.

''(vi) The factor described in section 1935(c)(5) is deemed to be 90 percent.

''(3) APPLICABLE DUAL ELIGIBLE BCP ENROLLEE.—For purposes of this section, the term 'applicable dual eligible BCP enrollee' means, with respect to a State, an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section) for such State who is enrolled in a qualified BCP under section 1899B. Such term includes, in the case of medical assistance for medicare cost-sharing under a State plan under this title, an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to such medicare cost-sharing and who is enrolled in such a qualified BCP.

''(b) COORDINATION OF BENEFITS.—

''(1) MEDICARE AS PRIMARY PAYOR.—In the case of an applicable dual eligible BCP enrollee, notwithstanding any other provision of this title, medical assistance is not available under this title for health care items or services (or for any cost-sharing respecting such health care items and services), and the rules under this title relating to the provision of medical assistance for such health care items and services shall not apply. The provision of benefits with respect to such health care items and services shall not be considered as the provision of care or services under the plan under this title. No payment may be made under section 1903(a) for health care items and services for which medical assistance is not available pursuant to this paragraph.

''(2) COVERAGE OF LONG-TERM CARE SERVICES.—In the case of medical assistance under this title with respect to coverage of long-term care services furnished to an applicable dual eligible BCP enrollee, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such qualified BCP. In no case shall a qualified BCP be required to provide to enrollees coverage of long-term care services.''.

(c) STATE MARKETING MATERIALS FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (80), by striking ''and'' at the end;

(B) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (81) the following:

''(82) provide that any marketing materials distributed by the State that are directed at dual eligible individuals (as defined in section 1915(h)(2)(B)) include information on qualified BCPs offered under section 1899B.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 2017, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(d) PROHIBITION ON COVERAGE OF COST-SHARING FOR CERTAIN ITEMS AND SERVICES FURNISHED TO AN ENROLLEE OUTSIDE OF A QUALIFIED BCP UNDER MEDIGAP POLICIES.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(z) PROHIBITION ON COVERAGE OF COST-SHARING FOR CERTAIN ITEMS AND SERVICES FURNISHED TO AN ENROLLEE OUTSIDE OF A QUALIFIED BCP AND DEVELOPMENT OF NEW STANDARDS FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) DEVELOPMENT.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from the enactment of the Better Care, Lower Cost Act and to otherwise update standards to include the requirements for cost sharing described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Better Care, Lower Cost Act To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2017.

''(2) COST SHARING REQUIREMENTS.—The cost sharing requirements described in this paragraph are that, notwithstanding any other provision of law, no medicare supplemental policy may provide for coverage of cost sharing with respect to items and services (other than emergent services, as defined by the Secretary) furnished to an individual enrolled in a qualified BCP under section 1899B by a provider of services or supplier that is not a qualified BCP professional (as defined in section 1899B(k)).

''(3) RENEWABILITY.—The renewability requirement under subsection (q)(1) shall be satisfied with the renewal of the revised package under paragraph (1) that most closely matches the policy in which the individual was enrolled prior to such revision.''.

SEC. 4. CHRONIC SPECIAL NEEDS PLANS.

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

(1) in subsection (f)(4)—

(A) by striking ''In the case of'' and inserting ''Subject to subsection (h), in the case of''; and

(B) by adding at the end the following flush text:

''Notwithstanding any other provision of this section, on or after January 1, 2014, the Secretary shall establish procedures for the transition of those individuals to a Medicare Advantage plan qualified BCP in accordance with subsection (h).''; and

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

''(h) MEDICARE ADVANTAGE PLAN QUALIFIED BCPS.—

''(1) IN GENERAL.—A Medicare Advantage plan that is certified as a qualified BCP (referred to in this subsection as a 'Medicare Advantage plan qualified BCP')—

''(A) is deemed to be a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii); and

''(B) may enroll such special needs individuals.

''(2) SPECIALIZED BENEFIT PACKAGES.—A Medicare Advantage plan qualified BCP shall have the flexibility to offer specialized benefit packages to enrollees described in subsection (b)(6)(B)(iii), consistent with the value-based insurance requirements under section 1899B(f).

''(3) APPLICATION OF BCP REQUIREMENTS.—A Medicare Advantage plan qualified BCP shall be subject to all requirements applicable to a qualified BCP under section 1899B, including enrollment periods under subsection (c) of that section, applicable criteria relating to network adequacy, requirements with respect to individual patient-centered chronic care plans under subsection (d)(2) of that section, applicable criteria with respect to care management processes, and quality reporting under subsection (h) of that section.

''(4) APPLICATION OF PART C REQUIREMENTS.—The provisions of this part, including the provisions relating to specialized MA plans for special needs individuals described in subsection (b)(6)(B)(iii), shall apply to a Medicare Advantage plan qualified BCP to the extent they are consistent with the provisions of section 1899B.''.

SEC. 5. IMPROVEMENTS TO WELCOME TO MEDICARE VISIT AND ANNUAL WELLNESS VISITS.

(a) WELCOME TO MEDICARE VISIT.—Section 1861(ww)(1) of the Social Security Act (42 U.S.C. 1395x(ww)(1)) is amended by adding at the end the following new sentence: ''In the case of a BCP eligible individual (as defined in section 1899B(b)), such term includes a standardized functional and health risk assessment (as described in section 1899B(d)(1)) furnished by a qualified BCP professional (as defined in section 1899B(k)).''.

(b) ANNUAL WELLNESS VISIT.—Section 1861(hhh)(1) of the Social Security Act (42 U.S.C. 1395x(h)(1)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) in the case of a BCP eligible individual (as defined in section 1899B(b)), that includes a standardized functional and health risk assessment (as described in section 1899B(d)(1)) furnished by a qualified BCP professional (as defined in section 1899B(k)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date that is one year after the date of enactment of this Act.

SEC. 6. CHRONIC CARE INNOVATION CENTERS.

(a) DESIGNATION.—Not later than October 1, 2016, the Secretary, acting through the Agency for Healthcare Research and Quality, shall designate and provide core funding for not less than three Chronic Care Innovation Centers. The Secretary shall develop a process for entities seeking to become a Chronic Care Innovation Center, and shall ensure sufficient geographic representation among those entities selected. The main objectives of such Centers shall include the following:

(1) Improving the understanding of how to measure, monitor, and understand quality and efficiency for a patient population with substantial disease burden.

(2) Rigorously examining alternative and innovative systems and strategies for efficiently improving quality and outcomes for common, serious, and chronic illnesses.

(3) Developing and applying improved methodologies for informing policymakers regarding heterogeneity in the effectiveness and safety of proposed interventions, and assessing barriers to the implementation of high-priority care.

(4) Studying organization and management practices that result in higher quality of care.

(5) Defining and improving quality of care for patients with the chronic diseases prevalent in primary care settings.

(6) Understanding the influence of race, ethnicity, and cultural factors on access, quality, and outcomes (such as clinical, patient-centered, health care utilization, and costs).

(7) Evaluating new technology to enhance access to, and quality of care (such as telemedicine).

(8) Assessing the use of patient self-management and behavioral interventions as a means of improving outcomes for Medicare beneficiaries with complex chronic conditions.

(9) Understanding how management of care is affected when patients have multiple chronic conditions in which evidence or recommended guidelines are lacking, conflict with, or complicate overall care management.

(10) Characterizing coordination of care within and across healthcare systems, including the Department of Veterans Affairs, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid program under title XIX of such Act, and private sector programs for veterans with complex chronic conditions.

(b) REQUIREMENTS.—In order to be designated a Chronic Care Innovation Center under this section, each eligible entity must meet the following requirements:

(1) Develop and implement a sustained research agenda in the field of chronic care.

(2) Collaborate with local schools of public health and universities to cary out its mission.

(3) Actively engage in the development of new, best practices for the delivery of care to the chronically ill.

(4) Actively engage in the development and routine updating of quality measures for the chronically ill.

(5) Have the ability to convene experts practiced in the needs of a chronically ill patient, including pharmacologists, psychiatrists, cardiologists, pulmonologists, rheumatologists, nutritionists and dieticians, social workers, and physical therapists.

(6) Partner with the Secretary of Health and Human Services and the Secretary of Veterans Affairs (including the Center for Health Services Research in Primary Care of the Department of Veterans Affairs Health Services Research and Development Service), the medical community, medical schools, and public health departments through the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Association of American Medical Colleges to routinely develop new, forward thinking, and evidence-based curricula that addresses the tremendous need for team-based care and chronic care management. Such curricula shall include palliative medicine, chronic care management, leadership and team-based skills and planning, and leveraging technology as a care tool.

(c) OVERSIGHT AND EVALUATION.—

(1) IN GENERAL.—The Agency for Healthcare Research and Quality shall be responsible for oversight and evaluation of all Chronic Care Innovation Centers under this section.

(2) REPORTS.—Not less frequently than every 3 years, the Agency for Healthcare Research and Quality shall submit to the Secretary of Health and Human Services and to Congress a report containing the findings of oversight and evaluations conducted under paragraph (1).

(d) CONTRACT AUTHORITY.—In order to carry out this section, the Secretary may contract with existing Centers of Innovation (COINs) of the Department of Veterans Affairs Health Services Research and Development Service that meet the requirements described in subsection (c).

(e) AUTHORIZATION.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 7. CURRICULA REQUIREMENTS FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

''(9) NEW CURRICULA REQUIREMENTS.—

''(A) DEVELOPMENT.—The Secretary shall engage with the medical community and medical schools in developing curricula that meets the following requirements:

''(i) The curricula is new, forward thinking, and evidence-based.

''(ii) The curricula addresses the need for team-based care and chronic care management.

''(iii) The curricula includes palliative medicine, chronic care management, leadership and team-based skills and planning, and leveraging technology as a care tool.

''(B) RURAL AREAS.—The curricula developed under subparagraph (A) shall include appropriate focus on care practices required for rural and underserved areas.

''(C) LIMITATION.—Notwithstanding the preceding provisions of this subsection, for cost reporting periods beginning on or after the date that is 5 years after the date of enactment of the Better Care, Lower Cost Act, if a hospital has not begun to implement curricula that meets the requirements described in subparagraph (A), payments otherwise made to a hospital under this subsection may be reduced by a percentage determined appropriate by the Secretary. For purposes of the preceding sentence, successful development and implementation of such curricula shall be determined by program accrediting bodies.''.

(b) INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by redesignating clause (x), as added by section 5505(b) of the Patient Protection and Affordable Care Act (Public Law 111–148), as clause (xi) and moving such clause 6 ems to the left; and

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

''(xii) Notwithstanding the preceding provisions of this subparagraph, effective for discharges occurring on or after the date that is 5 years after the date of enactment of the Better Care, Lower Cost Act, if a hospital has not begun to implement curricula that meets the requirements described in subsection (h)(9)(A), as determined in accordance with subsection (h)(9)(C), payments otherwise made to a hospital under this subparagraph may be reduced by a percentage determined appropriate by the Secretary.''.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2652. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1846, to delay the implementation of certain provisions of the Biggert-Waters Flood Insurance Reform Act of 2012, and for other purposes; which was ordered to lie on the table.

SA 2653. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1846, supra; which was ordered to lie on the table.

SA 2654. Mr. HELLER (for himself and Mr. LEE) submitted an amendment intended to be proposed by him to the bill S. 1846, supra; which was ordered to lie on the table.

SA 2655. Mr. REID proposed an amendment to the bill H.R. 3547, to extend Government liability, subject to appropriation, for certain third-party claims arising from commercial space launches.

SA 2656. Mr. REID proposed an amendment to amendment SA 2655 proposed by Mr. REID to the bill H.R. 3547, supra.

SA 2657. Mr. REID proposed an amendment to the bill H.R. 3547, supra.

SA 2658. Mr. REID proposed an amendment to amendment SA 2657 proposed by Mr. REID to the bill H.R. 3547, supra.

SA 2659. Mr. REID proposed an amendment to amendment SA 2658 proposed by Mr. REID to the amendment SA 2657 proposed by Mr. REID to the bill H.R. 3547, supra.

TEXT OF AMENDMENTS

SA 2652. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1846, to delay the implementation of certain provisions of the Biggert-Waters Flood Insurance Reform Act of 2012, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. STUDY OF VOLUNTARY COMMUNITY-BASED FLOOD INSURANCE OPTIONS.

(a) STUDY.—

(1) STUDY REQUIRED.—The Administrator shall conduct a study to assess options, methods, and strategies for making available voluntary community-based flood insurance policies through the National Flood Insurance Program.

(2) CONSIDERATIONS.—The study conducted under paragraph (1) shall—

(A) take into consideration and analyze how voluntary community-based flood insurance policies—

(i) would affect communities having varying economic bases, geographic locations, flood hazard characteristics or classifications, and flood management approaches; and

(ii) could satisfy the applicable requirements under section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a); and

(B) evaluate the advisability of making available voluntary community-based flood insurance policies to communities, subdivisions of communities, and areas of residual risk.

(3) CONSULTATION.—In conducting the study required under paragraph (1), the Administrator may consult with the Comptroller General of the United States, as the Administrator determines is appropriate.

(b) REPORT BY THE ADMINISTRATOR.—

(1) REPORT REQUIRED.—Not later than 18 months after the date of enactment of this Act, the Administrator shall submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives a report that contains the results and conclusions of the study conducted under subsection (a).

(2) CONTENTS.—The report submitted under paragraph (1) shall include recommendations for—

(A) the best manner to incorporate voluntary community-based flood insurance policies into the National Flood Insurance Program; and

(B) a strategy to implement voluntary community-based flood insurance policies that would encourage communities to undertake flood mitigation activities, including the construction, reconstruction, or improvement of levees, dams, or other flood control structures.

(c) REPORT BY COMPTROLLER GENERAL.—Not later than 6 months after the date on which the Administrator submits the report required under subsection (b), the Comptroller General of the United States shall—

(1) review the report submitted by the Administrator; and

(2) submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives a report that contains—

(A) an analysis of the report submitted by the Administrator;

(B) any comments or recommendations of the Comptroller General relating to the report submitted by the Administrator; and

(C) any other recommendations of the Comptroller General relating to community-based flood insurance policies.

SA 2653. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1846, to delay the implementation of certain provisions of the Biggert-Waters Flood Insurance Reform Act of 2012, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. STUDY OF VOLUNTARY COMMUNITY-BASED FLOOD INSURANCE OPTIONS.

(a) STUDY.—

(1) STUDY REQUIRED.—The Administrator shall conduct a study to assess options, methods, and strategies for making available voluntary community-based flood insurance policies through the National Flood Insurance Program.

(2) CONSIDERATIONS.—The study conducted under paragraph (1) shall—

(A) take into consideration and analyze how voluntary community-based flood insurance policies—

(i) would affect communities having varying economic bases, geographic locations, flood hazard characteristics or classifications, and flood management approaches; and

(ii) could satisfy the applicable requirements under section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a); and

(B) evaluate the advisability of making available voluntary community-based flood insurance policies to communities, subdivisions of communities, and areas of residual risk.

(3) CONSULTATION.—In conducting the study required under paragraph (1), the Administrator may consult with the Comptroller General of the United States, as the Administrator determines is appropriate.

(b) REPORT BY THE ADMINISTRATOR.—

(1) REPORT REQUIRED.—Not later than 18 months after the date of enactment of this Act, the Administrator shall submit to the Committee on Banking, Housing, and Urban