S. 1989

To improve access to primary care services.

IN THE SENATE OF THE UNITED STATES

AUGUST 5, 2015

Mr. Cassidy introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To improve access to primary care services.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Primary Care En-
hancement Act of 2015”.

SEC. 2. TREATMENT OF DIRECT PRIMARY CARE SERVICE

ARRANGEMENTS.

(a) In general.—Section 223(c) of the Internal
Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(6) TREATMENT OF DIRECT PRIMARY CARE
SERVICE ARRANGEMENTS.—An arrangement under
which an individual is provided ongoing primary care
services in exchange for a fixed periodic fee which is
not billed to any third party on a fee for service
basis—

“(A) shall not be treated as a health plan
for purposes of paragraph (1)(A)(ii), and
“(B) shall not be treated as insurance for
purposes of subsection (d)(2)(B).”.

(b) Effective Date.—The amendment made by
this section shall apply to taxable years beginning after
the date of the enactment of this Act.

SEC. 3. CERTAIN PROVIDER FEES TO BE TREATED AS MED-
ICAL CARE.

(a) In General.—Subsection (d) of section 213 of
the Internal Revenue Code of 1986 is amended by adding
at the end the following new paragraph:

“(12) Periodic provider fees.—The term
‘medical care’ shall include periodic fees paid to a
primary care physician for a defined set of medical
services on an as-needed basis.”.

(b) Effective Date.—The amendment made by
this section shall apply to taxable years beginning after
the date of the enactment of this Act.
Section 1115A of title XI of the Social Security Act (42 U.S.C. 1315a) is amended—

(1) in subsection (b)(2)(A), in the last sentence, by inserting “, and shall include the model described in subsection (h)” before the period at the end; and

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

“(h) Primary Care Medical Home Model.—

“(1) Model.—

“(A) In General.—The model described in this subsection is a model under which qualified direct primary care medical home practices are reimbursed a periodic fee for furnishing services to an individual enrolled under part B of title XVIII.

“(B) Qualified Direct Primary Care Medical Home Practice.—In this subsection, the term ‘qualified direct primary care medical home practice’ means a qualified direct primary care medical home practice described in section 1301(a)(3) of the Patient Protection and Affordable Care Act (as amended by section 10104(a) of such Act).

“(2) Periodic Fee.—
“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the Secretary shall establish the periodic fee to be paid to qualified direct primary care medical home practices participating in the model under this subsection for each individual enrolled in the practice.

“(B) AFFORDABLE PRIMARY CARE.—In no case may a monthly equivalent of the periodic fee established by the Secretary under subparagraph (A) exceed an amount equal to twenty percent of the average per capita monthly amount that the Secretary estimates will be payable from the Federal Hospital Insurance Trust Fund under section 1817 and from the Federal Supplementary Medical Insurance Trust Fund for services and related administrative costs for an individual under parts A and B of title XVIII.

“(C) ADJUSTMENT TO PERIODIC FEE.—

“(i) PERFORMANCE BENCHMARK.—The Secretary shall establish a performance benchmark for a year using the ACO quality measures in the Medicare shared savings program under section 1899.
“(ii) ADJUSTMENT.—Beginning with
the second year the model under this sub-
section is conducted, in the case of a qual-
ified direct primary care medical home
practice participating in the model under
this subsection—

“(I) that meets or exceeds the
performance benchmark for the year
under clause (i), the periodic fee paid
to the practice for each individual en-
rolled in the practice shall be in-
creased by 5 percent; and

“(II) that does not meet the per-
formance benchmark for the year
under clause (i), the periodic fee paid
to the practice for each individual en-
rolled in the practice shall be reduced
by 5 percent.

“(3) TERMINATION IF PERFORMANCE BENCH-
MARK NOT MET FOR 2 CONSECUTIVE YEARS.—The
Secretary shall terminate the participation of a
qualified direct primary care medical home practice
in the model under this subsection if the practice
would otherwise be subject to the adjustment under
paragraph (2)(C)(ii)(II) for 2 consecutive years.
“(4) Scope of services.—Each qualified direct primary care medical home practice shall employ the following activities and functions associated with direct primary care medical homes:

“(A) Preventive care.

“(B) Wellness counseling.

“(C) Primary care.

“(D) Coordination of primary care with specialty and hospital care.

“(E) Availability of ongoing care appointments 7 days per week.

“(F) Secure e-mail and telephone consultation.

“(G) Availability of telephone access for ongoing care consultation on a 7-day-per-week, 24-hour-per-day basis.

“(H) Use of a primary care provider panel size that promotes the ability of participating providers to appropriately provide the scope of services described in this paragraph.

“(5) Priority.—

“(A) In general.—In selecting qualified direct primary care medical home practices to participate under this subsection, the Secretary shall provide priority to practices that seek to...
enroll individuals who are dual eligible individuals.

“(B) DUAL ELIGIBLE INDIVIDUAL.—In
subparagraph (A), the term ‘dual eligible individual’ means an individual who is—

“(i) enrolled under part B of title

XVIII; and

“(ii) described in subparagraph (A)(ii)
of section 1935(c)(6) of the Social Security

Act (42 U.S.C. 1396u–5(c)(6)), taking into

account the application of subparagraph

(B) of such section.

“(6) NOT INSURANCE.—Care provided in a

qualified direct primary care medical home practice participating in the model under this subsection
shall not be considered an insurance product and
shall not be subject to regulation as an insurance product or health maintenance organization by State
insurance commissioners.

“(7) REPORTING TO SECRETARY.—A qualified
direct primary care medical home practice participat-
ing in the model under this subsection shall sub-
mit to the Secretary an annual report on—
“(A) the progress, of individuals enrolled in the practice with one or more chronic conditions, on the following:

“(i) Emergency room visits.

“(ii) Hospitalizations.

“(iii) Surgeries (including type of surgery).

“(iv) Specialist visits.

“(v) Use of advanced radiology (other than mammograms and DEXA scans); and

“(B) such other areas determined appropriate by the Secretary.

“(8) Provision of data to practices.—The Secretary shall provide qualified direct primary care medical home practices participating in the model under this subsection with all necessary and relevant patient data, including any prior claims data, needed for clinical purposes and for the purpose of providing an evaluation of such the model under this subsection.

“(9) Providers currently opted out of Medicare.—Notwithstanding section 1802(b), a physician or practitioner who has currently opted out of the Medicare program under such section may participate in a qualified direct primary care medical
home practice participating in the model under this
subsection and payment may be made under this
title with respect to items and services furnished by
such physician or practitioner under such model to
Medicare beneficiaries with whom the physician or
practitioner has in effect a private contract under
such section.

“(10) Fraud.—A physician or practitioner who
has been excluded from participation in a Federal
health care program (as defined in section 1128C(f))
shall not be permitted to participate in a qualified
direct primary care medical home practice under the
model under this subsection.

“(11) Duration.—Subject to subsection
(b)(3), the Secretary shall conduct the model under
this subsection for a period of not less than 3 years.

“(12) Expansion.—Notwithstanding sub-
section (c), if the Secretary determines, after the
third year that the model under this subsection is
conducted, that—

“(A) a qualified direct primary care med-
ical home practice participating in the model
under this subsection meets the requirements
under paragraphs (1), (2), and (3) of such sub-
section, such practice shall continue perma-
nently as long as it continues to meet such re-
quirements and the other requirements of this
subsection; and

“(B) a majority of qualified direct primary
care medical home practice participating in the
model under this subsection meet the require-
ments under paragraphs (1), (2), and (3) of
such subsection, the Secretary shall expand the
model on a nationwide basis.”.

SEC. 5. USE OF DIRECT PRIMARY CARE MEDICAL HOMES
UNDER THE MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—Nothing in title XVIII of the So-
cial Security Act or any other provision of law shall be
construed to prohibit a Medicare Advantage organization
offering a Medicare Advantage plan under part C of such
title from—

(1) contracting with a qualified direct primary
care medical home practice to offer primary care
services under such plan; or

(2) including in such contract provisions for
shared savings agreed upon between the Medicare
Advantage organization and the qualified direct
primary care medical home practice.
(b) Qualified Direct Primary Care Medical Home Practice.—In this section, the term “qualified direct primary care medical home practice” means a qualified direct primary care medical home practice described in section 1301(a)(3) of the Patient Protection and Affordable Care Act (as amended by section 10104(a) of such Act).