HR 5841

To amend title XVIII of the Social Security Act to establish a population based payment demonstration project under which Patient Care Networks are paid prospective monthly capitated payments for coordinated care furnished to Medicare beneficiaries.

Congress: 114 (2015–2017, Ended)
Chamber: House
Policy Area: Health
Introduced: Jul 14, 2016
Current Status: Referred to the Subcommittee on Health.
Latest Action: Referred to the Subcommittee on Health. (Aug 2, 2016)
Official Text: https://www.congress.gov/bill/114th-congress/house-bill/5841

Sponsor

Name: Rep. Kelly, Mike [R-PA-3]
Party: Republican • **State:** PA • **Chamber:** House

Cosponsors (1 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Neal, Richard E. [D-MA-1]	D · MA		Jul 14, 2016

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred To	Jul 14, 2016
Ways and Means Committee	House	Referred to	Aug 2, 2016

Subjects & Policy Tags

Policy Area:

Health

Related Bills

No related bills are listed.

Summary (as of Jul 14, 2016)

This bill amends title XVIII (Medicare) of the Social Security Act to establish a five-year, population-based payment demonstration project through which provider networks are prospectively paid monthly capitated payments for coordinated care furnished to Medicare beneficiaries.

To be eligible to participate in the project, a provider network must:

- be an integrated care system that provides Medicare services directly;
- include physicians in group practice arrangements, a federally qualified health center, and at least one hospital;
- enter into, and be responsible for making payments to providers under, appropriate contractual arrangements;
- be accountable for the quality, cost, and overall care of the network's participating beneficiaries;
- enter into a participation agreement with the Centers for Medicare & Medicaid Services (CMS); and
- meet other specified requirements.

CMS shall establish a process for prospectively assigning Medicare fee-for-service beneficiaries to a participating provider network. This process must allow beneficiaries to opt out of such assignment.

The bill limits Medicare payment for out-of-network services furnished to a participating beneficiary.

To calculate payments to participating networks, CMS shall: (1) determine a base annual prospective population health budget, (2) adjust such budget to account for the number and characteristics of participating beneficiaries with respect to each network, and (3) annually update the budget to account for population changes and Medicare program growth.

The bill establishes certain limits on total program expenditures for the program's initial three years.

CMS may expand the project's duration and scope under specified circumstances.

Actions Timeline

- **Aug 2, 2016:** Referred to the Subcommittee on Health.
- **Jul 14, 2016:** Introduced in House
- **Jul 14, 2016:** Referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.