

107TH CONGRESS  
1ST SESSION

# S. 1589

To amend title XVIII of the Social Security Act to expand medicare benefits to prevent, delay, and minimize the progression of chronic conditions, establish payment incentives for furnishing quality services to people with serious and disabling chronic conditions, and develop national policies on effective chronic condition care, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

OCTOBER 30, 2001

Mr. ROCKEFELLER (for himself, Mr. WELLSTONE, and Mr. BAUCUS) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to expand medicare benefits to prevent, delay, and minimize the progression of chronic conditions, establish payment incentives for furnishing quality services to people with serious and disabling chronic conditions, and develop national policies on effective chronic condition care, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the  
 3 “Medicare Chronic Care Improvement Act of 2001”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Definitions.

TITLE I—EXPANSION OF BENEFITS TO PREVENT, DELAY, AND  
 MINIMIZE THE PROGRESSION OF CHRONIC CONDITIONS.

Subtitle A—Improving Access to Preventive Services

Sec. 101. Definitions.

Sec. 102. Elimination of deductibles and coinsurance for existing preventive  
 health benefits.

Sec. 103. Institute of Medicine medicare prevention benefit study and report.

Sec. 104. Authority to administratively provide for coverage of additional pre-  
 ventive benefits.

Sec. 105. Fast-track consideration of prevention benefit legislation.

Subtitle B—Expansion of Access to Health Promotion Services

Sec. 111. Disease self-management demonstration projects.

Sec. 112. Medicare health education and risk appraisal program.

Subtitle C—Medicare Coverage for Care Coordination and Assessment  
 Services

Sec. 121. Care coordination and assessment services.

TITLE II—PAYMENT INCENTIVES FOR QUALITY CARE FOR INDIVIDUALS WITH SERIOUS AND DISABLING CHRONIC CONDITIONS

Sec. 201. Adjustments to fee-for-service payment systems.

Sec. 202. Medicare+Choice.

TITLE III—DEVELOPMENT OF NATIONAL POLICIES ON  
 EFFECTIVE CHRONIC CONDITION CARE

Sec. 301. Study and report on effective chronic condition care.

Sec. 302. Institute of Medicine medicare chronic condition care improvement  
 study and report.

6 **SEC. 2. DEFINITIONS.**

7 In this Act:

1           (1) SECRETARY.—Unless otherwise specifically  
2           provided, the term “Secretary” means the Secretary  
3           of Health and Human Services.

4           (2) SERIOUS AND DISABLING CHRONIC CONDI-  
5           TION.—The term “serious and disabling chronic con-  
6           dition” means, with respect to an individual, that  
7           the individual has at least one physical or mental  
8           condition and a licensed health care practitioner has  
9           certified within the preceding 12-month period  
10          that—

11                 (A) the individual has a level of disability  
12                 such that the individual is unable to perform  
13                 (without substantial assistance from another in-  
14                 dividual) for a period of at least 90 days due  
15                 to a loss of functional capacity—

16                         (i) at least 2 activities of daily living;

17                         or

18                         (ii) such number of instrumental ac-  
19                         tivities of daily living that is equivalent (as  
20                         determined by the Secretary) to the level  
21                         of disability described in clause (i);

22                 (B) the individual has a level of disability  
23                 equivalent (as determined by the Secretary) to  
24                 the level of disability described in subparagraph  
25                 (A); or

1 (C) the individual requires substantial su-  
2 pervision to protect the individual from threats  
3 to health and safety due to severe cognitive im-  
4 pairment.

5 (3) ACTIVITIES OF DAILY LIVING.—The term  
6 “activities of daily living” means each of the fol-  
7 lowing:

8 (A) Eating.

9 (B) Toileting.

10 (C) Transferring.

11 (D) Bathing.

12 (E) Dressing.

13 (F) Continence.

14 (4) INSTRUMENTAL ACTIVITIES OF DAILY LIV-  
15 ING.—The term “instrumental activities of daily liv-  
16 ing” means each of the following:

17 (A) Medication management.

18 (B) Meal preparation.

19 (C) Shopping.

20 (D) Housekeeping.

21 (E) Laundry.

22 (F) Money management.

23 (G) Telephone use.

24 (H) Transportation use.

1 **TITLE I—EXPANSION OF BENE-**  
 2 **FITS TO PREVENT, DELAY,**  
 3 **AND MINIMIZE THE PRO-**  
 4 **GRESSION OF CHRONIC CON-**  
 5 **DITIONS.**

6 **Subtitle A—Improving Access to**  
 7 **Preventive Services**

8 **SEC. 101. DEFINITIONS.**

9 In this title:

10 (1) **COST-EFFECTIVE BENEFIT.**—The term  
 11 “cost-effective benefit” means a benefit or technique  
 12 that has—

13 (A) been subject to peer review;

14 (B) been described in scientific journals;

15 and

16 (C) demonstrated value as measured by  
 17 unit costs relative to health outcomes achieved.

18 (2) **COST-SAVING BENEFIT.**—The term “cost-  
 19 saving benefit” means a benefit or technique that  
 20 has—

21 (A) been subject to peer review;

22 (B) been described in scientific journals;

23 and

24 (C) caused a net reduction in health care  
 25 costs for medicare beneficiaries.

1           (3) MEDICALLY EFFECTIVE.—The term “medi-  
 2       cally effective” means, with respect to a benefit or  
 3       technique, that the benefit or technique has been—

4                       (A) subject to peer review;

5                       (B) described in scientific journals; and

6                       (C) determined to achieve an intended goal  
 7       under normal programmatic conditions.

8           (4) MEDICALLY EFFICACIOUS.—The term  
 9       “medically efficacious” means, with respect to a ben-  
 10      efit or technique, that the benefit or technique has  
 11      been—

12                      (A) subject to peer review;

13                      (B) described in scientific journals; and

14                      (C) determined to achieve an intended goal  
 15      under controlled conditions.

16 **SEC. 102. ELIMINATION OF DEDUCTIBLES AND COINSUR-**  
 17 **ANCE FOR EXISTING PREVENTIVE HEALTH**  
 18 **BENEFITS.**

19       (a) IN GENERAL.—Section 1833 of the Social Secu-  
 20      rity Act (42 U.S.C. 1395l) is amended by inserting after  
 21      subsection (o) the following new subsection:

22       “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR  
 23      PREVENTIVE HEALTH ITEMS AND SERVICES.—The Sec-  
 24      retary shall not require the payment of any deductible or  
 25      coinsurance under subsection (a) or (b), respectively, of

1 any individual enrolled for coverage under this part for  
2 any of the following preventive health items and services:

3 “(1) Blood-testing strips, lancets, and blood  
4 glucose monitors for individuals with diabetes de-  
5 scribed in section 1861(n).

6 “(2) Diabetes outpatient self-management  
7 training services (as defined in section 1861(qq)(1)).

8 “(3) Pneumococcal, influenza, and hepatitis B  
9 vaccines and administration described in section  
10 1861(s)(10).

11 “(4) Screening mammography (as defined in  
12 section 1861(jj)).

13 “(5) Screening pap smear and screening pelvic  
14 exam (as defined in paragraphs (1) and (2) of sec-  
15 tion 1861(nn), respectively).

16 “(6) Bone mass measurement (as defined in  
17 section 1861(rr)(1)).

18 “(7) Prostate cancer screening test (as defined  
19 in section 1861(oo)(1)).

20 “(8) Colorectal cancer screening test (as de-  
21 fined in section 1861(pp)(1)).

22 “(9) Screening for glaucoma (as defined in sec-  
23 tion 1861(uu)).

24 “(10) Medical nutrition therapy services (as de-  
25 fined in section 1861(vv)(1)).”.

1 (b) WAIVER OF COINSURANCE.—

2 (1) IN GENERAL.—Section 1833(a)(1)(B) of the  
 3 Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is  
 4 amended to read as follows: “(B) with respect to  
 5 preventive health items and services described in  
 6 subsection (p), the amounts paid shall be 100 per-  
 7 cent of the fee schedule or other basis of payment  
 8 under this title for the particular item or service,”.

9 (2) ELIMINATION OF COINSURANCE IN OUT-  
 10 PATIENT HOSPITAL SETTINGS.—The third sentence  
 11 of section 1866(a)(2)(A) of the Social Security Act  
 12 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-  
 13 ing after “1861(s)(10)(A)” the following: “, preven-  
 14 tive health items and services described in section  
 15 1833(p),”.

16 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—  
 17 Section 1833(b)(1) of the Social Security Act (42 U.S.C.  
 18 1395l(b)(1)) is amended to read as follows: “(1) such de-  
 19 ductible shall not apply with respect to preventive health  
 20 items and services described in subsection (p),”.

21 (d) ADDING “LANCET” TO DEFINITION OF DME.—  
 22 Section 1861(n) of the Social Security Act (42 U.S.C.  
 23 1395x(n)) is amended by striking “blood-testing strips  
 24 and blood glucose monitors” and inserting “blood-testing  
 25 strips, lancets, and blood glucose monitors”.



1 (e) CONFORMING AMENDMENTS.—

2 (1) ELIMINATION OF COINSURANCE FOR CLIN-  
 3 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs  
 4 (1)(D)(i) and (2)(D)(i) of section 1833(a) of the So-  
 5 cial Security Act (42 U.S.C. 1395l(a)), as amended  
 6 by section 201(b)(1) of the Medicare, Medicaid, and  
 7 SCHIP Benefits Improvement and Protection Act of  
 8 2000 (114 Stat. 2763A–481), as enacted into law by  
 9 section 1(a)(6) of Public Law 106–554, are each  
 10 amended by inserting “or which are described in  
 11 subsection (p)” after “assignment-related basis”.

12 (2) ELIMINATION OF COINSURANCE FOR CER-  
 13 TAIN DME.—Section 1834(a)(1)(A) of the Social Se-  
 14 curity Act (42 U.S.C. 1395m(a)(1)(A)) is amended  
 15 by inserting “(or 100 percent, in the case of such an  
 16 item described in section 1833(p))” after “80 per-  
 17 cent”.

18 (3) ELIMINATION OF DEDUCTIBLES AND COIN-  
 19 SURANCE FOR COLORECTAL CANCER SCREENING  
 20 TESTS.—Section 1834(d) of the Social Security Act  
 21 (42 U.S.C. 1395m(d)) is amended—

22 (A) in paragraph (2)(C)—

23 (i) by striking “(C) FACILITY PAY-  
 24 MENT LIMIT.—” and all that follows

1 through “Notwithstanding subsections”  
 2 and inserting the following:

3 “(C) FACILITY PAYMENT LIMIT.—Notwith-  
 4 standing subsections”;

5 (ii) by striking “(I) in accordance”  
 6 and inserting the following:

7 “(i) in accordance”;

8 (iii) by striking “(II) are performed”  
 9 and all that follows through “payment  
 10 under” and inserting the following:

11 “(ii) are performed in an ambulatory  
 12 surgical center or hospital outpatient de-  
 13 partment,

14 payment under”; and

15 (iv) by striking clause (ii); and

16 (B) in paragraph (3)(C)—

17 (i) by striking “(C) FACILITY PAY-  
 18 MENT LIMIT.—” and all that follows  
 19 through “Notwithstanding subsections”  
 20 and inserting the following:

21 “(C) FACILITY PAYMENT LIMIT.—Notwith-  
 22 standing subsections”; and

23 (ii) by striking clause (ii).

24 (f) EFFECTIVE DATE.—The amendments made by  
 25 this section shall apply to services furnished on or after

1 the day that is 1 year after the date of enactment of this  
2 Act.

3 **SEC. 103. INSTITUTE OF MEDICINE MEDICARE PREVEN-**  
4 **TION BENEFIT STUDY AND REPORT.**

5 (a) STUDY.—

6 (1) IN GENERAL.—The Secretary shall contract  
7 with the Institute of Medicine of the National Acad-  
8 emy of Sciences to—

9 (A) conduct a comprehensive study of cur-  
10 rent literature and best practices in the field of  
11 health promotion and disease prevention among  
12 medicare beneficiaries, including the issues de-  
13 scribed in paragraph (2); and

14 (B) submit the report described in sub-  
15 section (b).

16 (2) ISSUES STUDIED.—The study required  
17 under paragraph (1) shall include an assessment  
18 of—

19 (A) whether each health promotion and  
20 disease prevention benefit covered under the  
21 medicare program is—

22 (i) medically effective (as defined in  
23 section 101(3)); or

1 (ii) a cost-effective benefit (as defined  
 2 in section 101(1)) or a cost-saving benefit  
 3 (as defined in section 101(2));

4 (B) utilization by medicare beneficiaries of  
 5 such benefits (including any barriers to or in-  
 6 centives to increase utilization);

7 (C) quality of life issues associated with  
 8 such benefits; and

9 (D) whether health promotion and disease  
 10 prevention benefits that are not covered under  
 11 the medicare program that would affect all  
 12 medicare beneficiaries are—

13 (i) likely to be medically effective (as  
 14 defined in section 101(3)); or

15 (ii) likely to be a cost-effective benefit  
 16 (as defined in section 101(1)) or a cost-  
 17 saving benefit (as defined in section  
 18 101(2));

19 (b) REPORTS.—

20 (1) THREE-YEAR REPORT.—On the date that is  
 21 3 years after the date of enactment of this Act, and  
 22 each successive 3-year anniversary thereafter, the  
 23 Institute of Medicine of the National Academy of  
 24 Sciences shall submit to the President a report that  
 25 contains—

1 (A) a detailed statement of the findings  
2 and conclusions of the study conducted under  
3 subsection (a); and

4 (B) the recommendations for legislation  
5 described in paragraph (3).

6 (2) INTERIM REPORT BASED ON NEW GUIDE-  
7 LINES.—If the United States Preventive Services  
8 Task Force or the Task Force on Community Pre-  
9 ventive Services establishes new guidelines regarding  
10 preventive health benefits for medicare beneficiaries  
11 more than 1 year prior to the date that a report de-  
12 scribed in paragraph (1) is due to be submitted to  
13 the President, then not later than 6 months after  
14 the date such new guidelines are established, the In-  
15 stitute of Medicine of the National Academy of  
16 Sciences shall submit to the President a report that  
17 contains a detailed description of such new guide-  
18 lines. Such report may also contain recommenda-  
19 tions for legislation described in paragraph (3).

20 (3) RECOMMENDATIONS FOR LEGISLATION.—  
21 The Institute of Medicine of the National Academy  
22 of Sciences, in consultation with the United States  
23 Preventive Services Task Force and the Task Force  
24 on Community Preventive Services, shall develop  
25 recommendations in legislative form that—

1 (A) prioritize the preventive health benefits  
2 under the medicare program; and

3 (B) modify such benefits, including adding  
4 new benefits under such program, based on the  
5 study conducted under subsection (a).

6 (c) TRANSMISSION TO CONGRESS.—

7 (1) IN GENERAL.—Subject to paragraph (2), on  
8 the day that is 6 months after the date on which the  
9 report described in paragraph (1) of subsection (b)  
10 (or paragraph (2) of such subsection if the report  
11 contains recommendations in legislative form de-  
12 scribed in subsection (b)(3)) is submitted to the  
13 President, the President shall transmit the report  
14 and recommendations to Congress.

15 (2) REGULATORY ACTION BY THE SECRETARY  
16 OF HEALTH AND HUMAN SERVICES.—If the Sec-  
17 retary of Health and Human Services has exercised  
18 the authority under section 104(a) to adopt by regu-  
19 lation one or more of the recommendations under  
20 subsection (b)(3), the President shall only submit to  
21 Congress those recommendations under subsection  
22 (b)(3) that have not been adopted by the Secretary.

23 (3) DELIVERY.—Copies of the report and rec-  
24 ommendations in legislative form required to be

1 transmitted to Congress under paragraph (1) shall  
2 be delivered—

3 (A) to both Houses of Congress on the  
4 same day;

5 (B) to the Clerk of the House of Rep-  
6 resentatives if the House is not in session; and

7 (C) to the Secretary of the Senate if the  
8 Senate is not in session.

9 **SEC. 104. AUTHORITY TO ADMINISTRATIVELY PROVIDE**  
10 **FOR COVERAGE OF ADDITIONAL PREVEN-**  
11 **TIVE BENEFITS.**

12 (a) IN GENERAL.—The Secretary of Health and  
13 Human Services may by regulation adopt any or all of  
14 the legislative recommendations developed by the Institute  
15 of Medicine of the National Academy of Sciences, in con-  
16 sultation with the United States Preventive Services Task  
17 Force and the Task Force on Community Preventive Serv-  
18 ices in a report under section 103(b)(3) (relating to  
19 prioritizing and modifying preventive health benefits  
20 under the medicare program and the addition of new pre-  
21 ventive benefits), consistent with subsection (b).

22 (b) ELIMINATION OF COST-SHARING.—With respect  
23 to items and services furnished under the medicare pro-  
24 gram that the Secretary has incorporated by regulation  
25 under subsection (a), the provisions of section 1833(p) of

1 the Social Security Act (relating to elimination of cost-  
 2 sharing for preventive benefits), as added by section  
 3 102(a), shall apply to those items and services in the same  
 4 manner as such section applies to the items and services  
 5 described in paragraphs (1) through (10) of such section.

6 (c) DEADLINE.—The Secretary must publish a notice  
 7 of rulemaking with respect to the adoption by regulation  
 8 under subsection (a) of any such recommendation within  
 9 6 months of the date on which a report described in sec-  
 10 tion 103(b) is submitted to the President.

11 **SEC. 105. FAST-TRACK CONSIDERATION OF PREVENTION**  
 12 **BENEFIT LEGISLATION.**

13 (a) RULES OF HOUSE OF REPRESENTATIVES AND  
 14 SENATE.—This section is enacted by Congress—

15 (1) as an exercise of the rulemaking power of  
 16 the House of Representatives and the Senate, re-  
 17 spectively, and is deemed a part of the rules of each  
 18 House of Congress, but—

19 (A) is applicable only with respect to the  
 20 procedure to be followed in that House of Con-  
 21 gress in the case of an implementing bill (as de-  
 22 fined in subsection (d)); and

23 (B) supersedes other rules only to the ex-  
 24 tent that such rules are inconsistent with this  
 25 section; and



(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 103(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Sen-

1           ate designated by the Majority Leader and  
2           Minority Leader.

3           (B) SPECIAL RULE.—If either House of  
4           Congress is not in session on the day on which  
5           such recommendations in legislative form are  
6           transmitted, the recommendations in legislative  
7           form shall be introduced as a bill in that House  
8           of Congress, as provided in subparagraph (A),  
9           on the first day thereafter on which that House  
10          of Congress is in session.

11          (2) REFERRAL.—Such bills shall be referred by  
12          the presiding officers of the respective Houses to the  
13          appropriate committee, or, in the case of a bill con-  
14          taining provisions within the jurisdiction of 2 or  
15          more committees, jointly to such committees for con-  
16          sideration of those provisions within their respective  
17          jurisdictions.

18          (c) CONSIDERATION.—After the recommendations in  
19          legislative form have been introduced as a bill and referred  
20          under subsection (b), such implementing bill shall be con-  
21          sidered in the same manner as an implementing bill is con-  
22          sidered under subsections (d), (e), (f), and (g) of section  
23          151 of the Trade Act of 1974 (19 U.S.C. 2191).

24          (d) IMPLEMENTING BILL DEFINED.—In this section,  
25          the term “implementing bill” means only the recommenda-

1 tions in legislative form of the Institute of Medicine of the  
 2 National Academy of Sciences described in section  
 3 103(b)(3), transmitted by the President to the House of  
 4 Representatives and the Senate under subsection 103(c),  
 5 and introduced and referred as provided in subsection (b)  
 6 as a bill of either House of Congress.

7 (e) COUNTING OF DAYS.—For purposes of this sec-  
 8 tion, any period of days referred to in section 151 of the  
 9 Trade Act of 1974 shall be computed by excluding—

10 (1) the days on which either House of Congress  
 11 is not in session because of an adjournment of more  
 12 than 3 days to a day certain or an adjournment of  
 13 Congress sine die; and

14 (2) any Saturday and Sunday, not excluded  
 15 under paragraph (1), when either House is not in  
 16 session.

## 17 **Subtitle B—Expansion of Access to** 18 **Health Promotion Services**

### 19 **SEC. 111. DISEASE SELF-MANAGEMENT DEMONSTRATION** 20 **PROJECTS.**

21 (a) DEMONSTRATION PROJECTS.—

22 (1) IN GENERAL.—The Secretary shall conduct  
 23 demonstration projects for the purpose of promoting  
 24 disease self-management for conditions identified,

1 and appropriately prioritized, by the Secretary for  
 2 target individuals (as defined in paragraph (2)).

3 (2) TARGET INDIVIDUAL DEFINED.—In this  
 4 section, the term “target individual” means an indi-  
 5 vidual who—

6 (A) is at risk for, or has, 1 or more of the  
 7 conditions identified by the Secretary as being  
 8 appropriate for disease self-management; and

9 (B) is entitled to benefits under part A of  
 10 title XVIII of the Social Security Act (42  
 11 U.S.C. 1395c et seq.), or enrolled under part B  
 12 of such title ( 42 U.S.C. 1395j et seq.) or is en-  
 13 rolled under the Medicare+Choice program  
 14 under part C of such title (42 U.S.C. 1395w–  
 15 21 et seq.).

16 (b) NUMBER; PROJECT AREAS; DURATION.—

17 (1) NUMBER.—Not later than 2 years after the  
 18 date of enactment of this Act, the Secretary shall  
 19 implement a series of demonstration projects to  
 20 carry out the purpose described in subsection (a)(1).

21 (2) PROJECT AREAS.—The Secretary shall im-  
 22 plement the demonstration projects described in  
 23 paragraph (1) in urban, suburban, and rural areas.

24 (3) DURATION.—The demonstration projects  
 25 under this section shall be conducted during the 3-

1 year period beginning on the date on which the ini-  
2 tial demonstration project is implemented.

3 (c) REPORT TO CONGRESS.—

4 (1) IN GENERAL.—Not later than 18 months  
5 after the conclusion of the demonstration projects  
6 under this section, the Secretary shall submit a re-  
7 port to Congress on such projects.

8 (2) CONTENTS OF REPORT.—The report re-  
9 quired under paragraph (1) shall include the fol-  
10 lowing:

11 (A) A description of the demonstration  
12 projects.

13 (B) An evaluation of—

14 (i) whether each benefit provided  
15 under the demonstration projects is—

16 (I) medically effective;

17 (II) medically efficacious;

18 (III) cost-effective; or

19 (IV) cost-saving;

20 (ii) the level of the disease self-man-  
21 agement attained by target individuals  
22 under the demonstration projects; and

23 (iii) the satisfaction of target individ-  
24 uals under the demonstration projects.

1 (C) Recommendations of the Secretary re-  
 2 garding whether to conduct the demonstration  
 3 projects on a permanent basis.

4 (D) Such recommendations for legislation  
 5 and administrative action as the Secretary de-  
 6 termines to be appropriate.

7 (E) Any other information regarding the  
 8 demonstration projects that the Secretary de-  
 9 termines to be appropriate.

10 (d) FUNDING.—The Secretary shall provide for the  
 11 transfer from the Federal Hospital Insurance Trust Fund  
 12 under section 1817 of the Social Security Act (42 U.S.C.  
 13 1395i) an amount not to exceed \$30,000,000 for the costs  
 14 of carrying out this section.

15 **SEC. 112. MEDICARE HEALTH EDUCATION AND RISK AP-**  
 16 **PRAISAL PROGRAM.**

17 Title XVIII of the Social Security Act (42 U.S.C.  
 18 1395 et seq.) is amended by adding at the end the fol-  
 19 lowing new section:

20 “MEDICARE HEALTH EDUCATION AND RISK APPRAISAL  
 21 PROGRAM

22 “SEC. 1897. (a) ESTABLISHMENT.—Not later than  
 23 18 months after the date of the conclusion of the dem-  
 24 onstration projects conducted under subsection (b)(1), the  
 25 Secretary shall establish a comprehensive and systematic

1 model for delivering health promotion and disease preven-  
 2 tion services that—

3 “(1) through self-assessment identifies—

4 “(A) behavioral risk factors, such as to-  
 5 bacco use, physical inactivity, alcohol use, de-  
 6 pression, lack of proper nutrition, and risk of  
 7 falling, among target individuals;

8 “(B) needed medicare clinical preventive  
 9 and screening health benefits among target in-  
 10 dividuals; and

11 “(C) functional and self-management in-  
 12 formation the Secretary determines to be appro-  
 13 priate;

14 “(2) provides ongoing followup to reduce risk  
 15 factors and promote the appropriate use of preven-  
 16 tive and screening health benefits;

17 “(3) improves clinical outcomes, satisfaction,  
 18 quality of life, and appropriate use by target individ-  
 19 uals of items and services covered under the medi-  
 20 care program; and

21 “(4) provides target individuals with informa-  
 22 tion regarding the adoption of healthy behaviors.

23 “(b) DEMONSTRATION PROJECTS.—

24 “(1) ESTABLISHMENT.—Not later than 1 year  
 25 after the date of enactment of this section, the Sec-

retary, in consultation with the Director of the Centers for Disease Control and Prevention, and the Director of the Agency for Healthcare Research and Quality, shall conduct demonstration projects for the purpose of developing a comprehensive and systematic model for delivering health promotion and disease prevention services described in subsection (a).

“(2) SELF-ASSESSMENT AND PROVISION OF INFORMATION.—The Secretary shall conduct the demonstration projects established under paragraph (1) in the following manner:

“(A) SELF-ASSESSMENT.—

“(i) IN GENERAL.—The Secretary shall test different—

“(I) methods of making self-assessments available to each target individual;

“(II) methods of encouraging each target individual to participate in the self-assessment; and

“(III) methods for processing responses to the self-assessment.

“(ii) CONTENTS.—A self-assessment made available under clause (i) shall include—



1 “(I) questions regarding behav-  
2 ioral risk factors;

3 “(II) questions regarding needed  
4 preventive screening health services;

5 “(III) questions regarding the  
6 target individual’s preferences for re-  
7 ceiving follow-up information; and

8 “(IV) other information that the  
9 Secretary determines appropriate.

10 “(B) PROVISION OF INFORMATION.—After  
11 each target individual completes the self-assess-  
12 ment, the Secretary shall ensure that the target  
13 individual is provided with such information as  
14 the Secretary determines appropriate, which  
15 may include—

16 “(i) information regarding the results  
17 of the self-assessment;

18 “(ii) recommendations regarding any  
19 appropriate behavior modification based on  
20 the self-assessment;

21 “(iii) information regarding how to  
22 access behavior modification assistance  
23 that promotes healthy behavior, including  
24 information on nurse hotlines, counseling

1 services, provider services, and case-man-  
 2 agement services;

3 “(iv) information, feedback, support,  
 4 and recommendations regarding any need  
 5 for clinical preventive and screening health  
 6 services or treatment; and

7 “(v) referrals to available community  
 8 resources in order to assist the target indi-  
 9 vidual in reducing health risks.

10 “(3) PROJECT AREAS AND DURATION.—

11 “(A) PROJECT AREAS.—The Secretary  
 12 shall implement the demonstration projects in  
 13 geographic areas that include urban, suburban,  
 14 and rural areas.

15 “(B) DURATION.—The Secretary shall  
 16 conduct the demonstration projects during the  
 17 3-year period beginning on the date on which  
 18 the first demonstration project is implemented.

19 “(c) REPORT TO CONGRESS.—

20 “(1) IN GENERAL.—Not later than 1 year after  
 21 the date on which the demonstration projects con-  
 22 clude, the Secretary shall submit to Congress a re-  
 23 port on such projects.

24 “(2) CONTENTS OF REPORT.—The report sub-  
 25 mitted under paragraph (1) shall—

1           “(A) describe the demonstration projects  
2           conducted under this section;

3           “(B) identify the demonstration project  
4           that is the most effective; and

5           “(C) contain such other information re-  
6           garding the demonstration projects as the Sec-  
7           retary determines appropriate.

8           “(3) MEASUREMENT OF EFFECTIVENESS.—For  
9           purposes of paragraph (2)(B), in identifying the  
10          demonstration project that is the most effective, the  
11          Secretary shall consider—

12           “(A) how successful the project was at—

13           “(i) reaching target individuals and  
14           engaging them in an assessment of the risk  
15           factors of such individuals;

16           “(ii) educating target individuals on  
17           healthy behaviors and getting such individ-  
18           uals to modify their behaviors in order to  
19           diminish the risk of chronic disease; and

20           “(iii) ensuring that target individuals  
21           were provided with necessary information;

22           “(B) the cost-effectiveness of the dem-  
23           onstration project; and

24           “(C) the degree of beneficiary satisfaction  
25           under the demonstration projects.

1       “(d) WAIVER AUTHORITY.—The Secretary may  
 2 waive such requirements under this title as the Secretary  
 3 determines necessary to carry out the demonstration  
 4 projects under this section.

5       “(e) FUNDING.—There are authorized to be appro-  
 6 priated \$25,000,000 to the Secretary for carrying out the  
 7 demonstration projects under this section.

8       “(f) DEFINITION OF TARGET INDIVIDUAL.—The  
 9 term ‘target individual’ means each individual who is—  
 10           “(1) entitled to benefits under part A or en-  
 11 rolled under part B, including an individual enrolled  
 12 under the Medicare+Choice program under part C;  
 13 or

14           “(2) between the ages of 50 and 64 and who  
 15 is not described in paragraph (1).”.

16 **Subtitle C—Medicare Coverage for**  
 17 **Care Coordination and Assess-**  
 18 **ment Services**

19 **SEC. 121. CARE COORDINATION AND ASSESSMENT SERV-**  
 20 **ICES.**

21       (a) SERVICES AUTHORIZED.—Title XVIII of the So-  
 22 cial Security Act (42 U.S.C. 1395 et seq.), as amended  
 23 by section 112, is further amended by adding at the end  
 24 the following new section:

1 “CARE COORDINATION AND ASSESSMENT SERVICES

2 “SEC. 1898. (a) PURPOSE.—The purpose of this sec-  
 3 tion is to provide assistance to a beneficiary with a serious  
 4 and disabling chronic condition (as defined in subsection  
 5 (f)(1)) to obtain the appropriate level and mix of follow-  
 6 up care.

7 “(b) ELECTION OF CARE COORDINATION AND AS-  
 8 SESSMENT SERVICES.—

9 “(1) IN GENERAL.—On or after January 1,  
 10 2003, a beneficiary with a serious and disabling  
 11 chronic condition may elect to receive care coordina-  
 12 tion services in accordance with the provisions of  
 13 this section under which, in appropriate cir-  
 14 cumstances, the eligible beneficiary has health care  
 15 services covered under this title managed and coordi-  
 16 nated by a care coordinator who is qualified under  
 17 subsection (e) to furnish care coordination services  
 18 under this section.

19 “(2) REVOCATION OF ELECTION.—An eligible  
 20 beneficiary who has made an election under para-  
 21 graph (1) may revoke that election at any time.

22 “(c) OUTREACH.—The Secretary shall provide for the  
 23 wide dissemination of information to beneficiaries and pro-  
 24 viders of services, physicians, practitioners, and suppliers

1 with respect to the availability of and requirements for  
 2 care coordination services under this section.

3 “(d) CARE COORDINATION AND ASSESSMENT SERV-  
 4 ICES DESCRIBED.—Care coordination services under this  
 5 section shall include the following:

6 “(1) BASIC CARE COORDINATION AND ASSESS-  
 7 MENT SERVICES.—

8 “(A) IN GENERAL.—Except as otherwise  
 9 provided in this section, eligible beneficiaries  
 10 who have made an election under this section  
 11 shall receive the following services:

12 “(i)(I) An initial assessment of an in-  
 13 dividual’s medical condition, functional and  
 14 cognitive capacity, and environmental and  
 15 psychosocial needs.

16 “(II) Annual assessments after the  
 17 initial assessment performed under sub-  
 18 clause (I), unless the physician or care co-  
 19 ordinator of the individual determines that  
 20 additional assessments are required due to  
 21 sentinel health events or changes in the  
 22 health status of the individual that may re-  
 23 quire changes in plans of care developed  
 24 for the individual.

1           “(ii) The development of an initial  
2 plan of care, and subsequent appropriate  
3 revisions to that plan of care.

4           “(iii) The management of, and refer-  
5 ral for, medical and other health services,  
6 including multidisciplinary care con-  
7 ferences and coordination with other pro-  
8 viders.

9           “(iv) The monitoring and manage-  
10 ment of medications.

11           “(v) Patient education and counseling  
12 services.

13           “(vi) Family caregiver education and  
14 counseling services.

15           “(vii) Self-management services, in-  
16 cluding health education and risk appraisal  
17 to identify behavioral risk factors through  
18 self-assessment.

19           “(viii) Providing access for consulta-  
20 tions by telephone with physicians and  
21 other appropriate health care professionals,  
22 including 24-hour availability of such pro-  
23 fessionals for emergency consultations.

24           “(ix) Coordination with the principal  
25 nonprofessional caregiver in the home.

1           “(x) Managing and facilitating transi-  
2           tions among health care professionals and  
3           across settings of care, including the fol-  
4           lowing:

5                   “(I) Pursuing the treatment op-  
6                   tion elected by the individual.

7                   “(II) Including any advance di-  
8                   rective executed by the individual in  
9                   the medical file of the individual.

10           “(xi) Activities that facilitate con-  
11           tinuity of care and patient adherence to  
12           plans of care.

13                   “(xii) Information about, and referral  
14                   to, hospice services, including patient and  
15                   family caregiver education and counseling  
16                   about hospice, and facilitating transition to  
17                   hospice when elected.

18                   “(xiii) Such other medical and health  
19                   care services for which payment would not  
20                   otherwise be made under this title as the  
21                   Secretary determines to be appropriate for  
22                   effective care coordination, including the  
23                   additional items and services as described  
24                   in subparagraph (B).



1           “(B) ADDITIONAL BENEFITS.—The Sec-  
2           retary may specify additional benefits for which  
3           payment would not otherwise be made under  
4           this title that may be available to eligible bene-  
5           ficiaries who have made an election under this  
6           section (subject to an assessment by the care  
7           coordinator of an individual beneficiary’s cir-  
8           cumstances and need for such benefits) in order  
9           to encourage the receipt of, or to improve the  
10          effectiveness of, care coordination services.

11          “(2) CARE COORDINATION AND ASSESSMENT  
12          REQUIREMENT.—Notwithstanding any other provi-  
13          sion of this title, with respect to items and services  
14          for which payment is made under this title furnished  
15          to a beneficiary for the diagnosis and treatment of  
16          the beneficiary’s serious and disabling chronic condi-  
17          tion, if the beneficiary has made an election to re-  
18          ceive care coordination and assessment services  
19          under this section, the Secretary may require that  
20          payment may only be made under this title for such  
21          items and services relating to such condition if the  
22          items and services have been furnished by or coordi-  
23          nated through the care coordinator. Under such pro-  
24          vision, the Secretary shall prescribe exceptions for  
25          emergency medical services (as described in section

1 1852(d)(3), but without regard to enrollment with a  
 2 Medicare+Choice organization), and other excep-  
 3 tions determined by the Secretary for the delivery of  
 4 timely and needed care.

5 “(e) CARE COORDINATORS.—

6 “(1) CONDITIONS OF PARTICIPATION.—In order  
 7 to be qualified to furnish care coordination and as-  
 8 sessment services under this section, an individual or  
 9 entity shall—

10 “(A) be a health care professional or entity  
 11 (which may include physicians, physician group  
 12 practices, or other health care professionals or  
 13 entities the Secretary may find appropriate)  
 14 meeting such conditions as the Secretary may  
 15 specify;

16 “(B) enter into a care coordination agree-  
 17 ment under paragraph (2); and

18 “(C) meet such criteria as the Secretary  
 19 may establish (which may include experience in  
 20 the provision of care coordination or primary  
 21 care physician’s services).

22 “(2) AGREEMENT TERM; PAYMENT.—

23 “(A) DURATION AND RENEWAL.—A care  
 24 coordination agreement under this subsection  
 25 shall—

1 “(i) be entered into for a period of 1  
 2 year and may be renewed if the Secretary  
 3 is satisfied that the care coordinator con-  
 4 tinues to meet the conditions of participa-  
 5 tion specified in paragraph (1);

6 “(ii) assure the compliance of the care  
 7 coordinator with such data collection and  
 8 reporting requirements as the Secretary  
 9 determines necessary to assess the effect of  
 10 care coordination on health outcomes; and

11 “(iii) contain such other terms and  
 12 conditions as the Secretary may require.

13 “(B) PAYMENT FOR SERVICES.—The Sec-  
 14 retary shall establish payment terms and condi-  
 15 tions and payment rates for basic care coordi-  
 16 nation and assessment services described in  
 17 subsection (d)(1). The Secretary may establish  
 18 new billing codes to carry out the provisions of  
 19 this subparagraph.

20 “(f) DEFINITIONS.—In this section:

21 “(1) SERIOUS AND DISABLING CHRONIC CONDI-  
 22 TION.—The term ‘serious and disabling chronic con-  
 23 dition’ means, with respect to an individual, that the  
 24 individual has at least one physical or mental condi-

tion and a licensed health care practitioner has certified within the preceding 12-month period that—

“(A) the individual has a level of disability such that the individual is unable to perform (without substantial assistance from another individual) for a period of at least 90 days due to a loss of functional capacity—

“(i) at least 2 activities of daily living;

or

“(ii) such number of instrumental activities of daily living that is equivalent (as determined by the Secretary) to the level of disability described in clause (i);

“(B) the individual has a level of disability equivalent (as determined by the Secretary) to the level of disability described in subparagraph (A); or

“(C) the individual requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

“(2) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ means each of the following:

“(A) Eating.

1 “(B) Toileting.

2 “(C) Transferring.

3 “(D) Bathing.

4 “(E) Dressing.

5 “(F) Continence.

6 “(3) INSTRUMENTAL ACTIVITIES OF DAILY LIV-  
7 ING.—The term ‘instrumental activities of daily liv-  
8 ing’ means each of the following:

9 “(A) Medication management.

10 “(B) Meal preparation.

11 “(C) Shopping.

12 “(D) Housekeeping.

13 “(E) Laundry.

14 “(F) Money management.

15 “(G) Telephone use.

16 “(H) Transportation use.

17 “(4) BENEFICIARY.—The term ‘beneficiary’  
18 means an individual entitled to benefits under part  
19 A, or enrolled under part B, including an individual  
20 enrolled under the Medicare+Choice program under  
21 part C.”.

22 (b) COVERAGE OF CARE COORDINATION AND AS-  
23 Sessment SERVICES AS A PART B MEDICAL SERVICE.—

24 (1) IN GENERAL.—Section 1861(s) of the So-  
25 cial Security Act (42 U.S.C. 1395x(s)) is amended—

1 (A) in the second sentence, by redesignating paragraphs (16) and (17) as clauses (i)  
 2 and (ii); and

4 (B) in the first sentence—

5 (i) by striking “and” at the end of  
 6 paragraph (14);

7 (ii) by striking the period at the end  
 8 of paragraph (15) and inserting “; and”;  
 9 and

10 (iii) by adding after paragraph (15)  
 11 the following new paragraph:

12 “(16) care coordination and assessment services  
 13 furnished by a care coordinator in accordance with  
 14 section 1866C.”.

15 (2) CONFORMING AMENDMENTS.—Sections  
 16 1864(a) 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of  
 17 such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and  
 18 1396n(a)(1)(B)(ii)(I)) are each amended by striking  
 19 “paragraphs (16) and (17)” each place it appears  
 20 and inserting “clauses (i) and (ii) of the second sen-  
 21 tence”.

22 (3) PART B COINSURANCE AND DEDUCTIBLE  
 23 NOT APPLICABLE TO CARE COORDINATION AND AS-  
 24 SESSMENT SERVICES.—

1 (A) COINSURANCE.—Section 1833(a)(1) of  
 2 the Social Security Act (42 U.S.C.  
 3 1395l(a)(1)), as amended by sections 105 and  
 4 223 of the Medicare, Medicaid, and SCHIP  
 5 Benefits Improvement and Protection Act of  
 6 2000, as enacted into law by section 1(a)(6) of  
 7 Public Law 106–554, is amended—

8 (i) by striking “and” at the end of  
 9 subparagraph (T); and

10 (ii) by inserting before the final semi-  
 11 colon “, and (V) with respect to care co-  
 12 ordination and assessment services de-  
 13 scribed in section 1861(s)(16) that are fur-  
 14 nished by, or coordinated through, a care  
 15 coordinator, the amounts paid shall be 100  
 16 percent of the payment amount established  
 17 under section 1866C”.

18 (B) DEDUCTIBLE.—Section 1833(b) of  
 19 such Act (42 U.S.C. 1395l(b)) is amended—

20 (i) by striking “and” at the end of  
 21 paragraph (5); and

22 (ii) by inserting before the final period  
 23 “, and (7) such deductible shall not apply  
 24 with respect to care coordination and as-

1                    assessment services (as described in section  
2                    1861(s)(16))”.

3                    (C) ELIMINATION OF COINSURANCE IN  
4                    OUTPATIENT HOSPITAL SETTINGS.—The third  
5                    sentence of section 1866(a)(2)(A) of such Act  
6                    (42 U.S.C. 1395cc(a)(2)(A)), as amended by  
7                    section 102(b)(2), is further amended by insert-  
8                    ing after “section 1833(p),” the following:  
9                    “with respect to care coordination and assess-  
10                  ment services (as described in section  
11                  1861(s)(16)),”.

12 **TITLE II—PAYMENT INCENTIVES**  
13 **FOR QUALITY CARE FOR INDIVIDUALS WITH SERIOUS AND**  
14 **DISABLING CHRONIC CONDI-**  
15 **TIONS**

17 **SEC. 201. ADJUSTMENTS TO FEE-FOR-SERVICE PAYMENT**  
18 **SYSTEMS.**

19            (a) IN GENERAL.—The Secretary of Health and  
20 Human Services shall provide for appropriate adjustments  
21 to each of the payment systems described in subsection  
22 (b) to take into account the additional costs incurred in  
23 providing items and services under the medicare program  
24 to medicare beneficiaries who suffer from serious and dis-  
25 abling chronic conditions, including the consideration of



1 the patient classification system (or other methodology)  
2 under subsection (d). The Secretary shall implement such  
3 adjustments for items and services furnished on or after  
4 October 1, 2005.

5 (b) PAYMENT SYSTEMS DESCRIBED.—The payment  
6 systems referred to in subsection (a) are the following:

7 (1) The prospective payment system for covered  
8 skilled nursing facility services under section  
9 1888(e) of such Act (42 U.S.C. 1395yy(e)).

10 (2) The prospective payment system for home  
11 health services under section 1895 of such Act (42  
12 U.S.C. 1395fff).

13 (3) The prospective payment system for out-  
14 patient hospital services under section 1833(t) of  
15 such Act (42 U.S.C. 1395l(t)).

16 (4) The physician fee schedule under section  
17 1848 of such Act (42 U.S.C. 1395w–4).

18 (5) The composite rate of payment for dialysis  
19 services under section 1881(b)(7) of such Act (42  
20 U.S.C. 1395rr(b)(7)).

21 (6) The payment rate for outpatient therapy  
22 services and comprehensive outpatient rehabilitation  
23 services under section 1834(k) of such Act (42  
24 U.S.C. 1395m(k)).

1           (7) The payment rate for partial hospitalization  
2           services established by the Secretary in regulations  
3           under title XVIII of such Act.

4           (8) The payment rate for hospice services under  
5           section 1814(i) of such Act (42 U.S.C. 1395f(i)).

6           (c) INTERIM REPORT.—Not later than 18 months  
7           after the date of enactment of this Act, the Secretary shall  
8           submit to Congress a report on the proposed adjustments  
9           required under subsection (a) to the payment systems de-  
10          scribed in subsection (b), the methodology employed by the  
11          Secretary in providing for such proposed adjustments, and  
12          an assessment of the impact of such adjustments on access  
13          to effective care for medicare beneficiaries.

14          (d) PATIENT CLASSIFICATION SYSTEM.—The Sec-  
15          retary shall develop a patient classification system or other  
16          methodology to predict costs within and across postacute  
17          care settings attributable to furnishing items and services  
18          to medicare beneficiaries who suffer from serious and dis-  
19          abling chronic conditions. The Secretary shall develop  
20          such system by not later than October 1, 2004, and shall  
21          consult with representatives of providers of services and  
22          individuals with expertise in health care financing and risk  
23          adjustment methodology in developing such system.

1 **SEC. 202. MEDICARE+CHOICE.**

2 (a) REVISIONS TO RISK ADJUSTMENT METHOD-  
3 OLOGY.—

4 (1) IN GENERAL.—The Secretary shall revise  
5 the risk adjustment methodology under section  
6 1853(a)(3) of the Social Security Act (42 U.S.C.  
7 1395w–23(a)(3)) applicable to payments to  
8 Medicare+Choice organizations offering specialized  
9 programs for frail elderly and at-risk beneficiaries to  
10 take into account variations in costs incurred by  
11 such organizations.

12 (2) METHODS CONSIDERED.—In revising the  
13 risk adjustment methodology under paragraph (1),  
14 the Secretary shall consider—

15 (A) hybrid risk adjustment payment sys-  
16 tems, such as partial capitation;

17 (B) new diagnostic and service markers  
18 that more accurately predict high risk;

19 (C) improving the structural components  
20 of the applicable method of payment, such as  
21 reducing payment lag, using multiple site diag-  
22 nostic data, and using several years of data;

23 (D) providing for adjustments to payment  
24 amounts for beneficiaries with comorbidities;

25 (E) testing concurrent risk adjustment  
26 methodologies; and

1 (F) testing payment methods using data  
 2 from specialized programs for frail elderly and  
 3 at-risk beneficiaries.

4 (3) IMPLEMENTATION.—The Secretary shall  
 5 implement such revisions to the risk adjustment  
 6 methodology for items and services furnished on or  
 7 after January 1, 2005.

8 (4) INTERIM REPORT.—Not later than January  
 9 1, 2004, the Secretary shall submit to Congress a  
 10 report on revision of the risk adjustment method-  
 11 ology required under paragraph (1), including a de-  
 12 scription of the methods considered and employed by  
 13 the Secretary in providing for such revision and an  
 14 assessment of the impacts of such methods on access  
 15 to effective care for medicare beneficiaries.

16 (b) INTERIM CONTINUATION OF BLENDED RATE FOR  
 17 SPECIALIZED PROGRAMS FOR FRAIL ELDERLY AND AT-  
 18 RISK MEDICARE BENEFICIARIES RESIDING IN INSTITU-  
 19 TIONS.—

20 (1) IN GENERAL.—In the case of a  
 21 Medicare+Choice organization that complies with  
 22 the requirements under paragraph (2) and that of-  
 23 fers a Medicare+Choice plan that provides for a  
 24 specialized program for frail elderly and at-risk  
 25 beneficiaries that exclusively serves beneficiaries in

1 institutions or beneficiaries that are entitled to med-  
 2 ical assistance under a State plan under title XIX,  
 3 notwithstanding section 1853(a)(3)(C)(ii) of the So-  
 4 cial Security Act (42 U.S.C. 1395w-23(a)(3)(C)(ii)),  
 5 such organization shall be paid according to the  
 6 method described in section 1853(a)(3)(C)(ii)(I)  
 7 until such time as the Secretary has implemented  
 8 the revised risk adjustment methodology required in  
 9 subsection (a).

10 (2) REQUIREMENTS.—A Medicare+Choice or-  
 11 ganization may not qualify for the payment method-  
 12 ology under paragraph (1) unless the organization  
 13 collects such data (and in such format) as the Sec-  
 14 retary requires to monitor quality of services pro-  
 15 vided, outcomes, and costs, including functional and  
 16 diagnostic data and information collected through  
 17 the Health Outcomes Survey.

18 (c) INTERIM CONTINUATION OF PAYMENT METH-  
 19 ODOLOGIES FOR DEMONSTRATION PROGRAMS.—

20 (1) IN GENERAL.—Notwithstanding any other  
 21 provision of law, payment methodologies for medi-  
 22 care demonstration programs for specialized pro-  
 23 grams for frail elderly and at-risk beneficiaries that  
 24 comply with the requirements under paragraph (2)  
 25 shall continue under the terms and conditions of the

1 demonstration authority, including the risk adjust-  
 2 ment factors and formula used for paying such dem-  
 3 onstration programs, until such time as the Sec-  
 4 retary has implemented the revised risk adjustment  
 5 methodology required in subsection (a).

6 (2) REQUIREMENTS.—A medicare demonstra-  
 7 tion program may not qualify for the payment meth-  
 8 odology under paragraph (1) unless the program col-  
 9 lects such data (and in such format) as the Sec-  
 10 retary requires to monitor quality of services pro-  
 11 vided, outcomes, and costs, including functional and  
 12 diagnostic data and information collected through  
 13 the Health Outcomes Survey.

14 (d) INTERIM DEMONSTRATION PROGRAM FOR ADDI-  
 15 TIONAL PAYMENTS FOR SPECIALIZED PROGRAMS.—

16 (1) IN GENERAL.—The Secretary shall establish  
 17 a demonstration program under which additional  
 18 payments (in such manner and amount as the Sec-  
 19 retary determines appropriate) may be made to a  
 20 Medicare+Choice organization that complies with  
 21 the requirements under paragraph (2) and that of-  
 22 fers a Medicare+Choice plan that—

23 (A) provides, directly or through contract,  
 24 for a specialized program of care for enrollees

1 with serious and disabling chronic conditions;  
2 and

3 (B) exclusively serves enrollees with serious  
4 and disabling chronic conditions or serves a dis-  
5 proportionate share of such enrollees.

6 (2) REQUIREMENTS.—A Medicare+Choice or-  
7 ganization may not qualify for additional payments  
8 under paragraph (1) unless the organization and the  
9 specialized program of care meet the following re-  
10 quirements:

11 (A) Under the specialized program of care,  
12 a clinical delivery system is established that  
13 meets the needs of such enrollees, including—

14 (i) methods to prevent, delay, or mini-  
15 mize the progression of disabilities;

16 (ii) disease management protocols,  
17 such as high risk screening to identify risk  
18 of hospitalization, nursing home placement,  
19 functional decline, death, and other factors  
20 that increase the costs of care provided;

21 (iii) appropriate specially trained  
22 health care staff, such as nurse practi-  
23 tioners, geriatric care managers, or mental  
24 health professionals; and

1 (iv) methods for promoting integra-  
2 tion of care, financing, and administrative  
3 functions across health care settings.

4 (B) The organization collects such data  
5 (and in such format) as the Secretary requires  
6 to monitor quality of services provided, out-  
7 comes, and costs, including functional and diag-  
8 nostic data and information collected through  
9 the Health Outcomes Survey.

10 (C) The organization employs quality  
11 standards and tracks quality indicators speci-  
12 fied by the Secretary that are relevant to the  
13 special needs of enrollees with serious and dis-  
14 abling chronic conditions.

15 (D) The organization does not receive pay-  
16 ments, or adjustment to payments, with respect  
17 to any enrollee by reason of subsection (b) or  
18 (c).

19 (3) WAIVER AUTHORITY.—The Secretary may  
20 waive such requirements of title XVIII of the Social  
21 Security Act as may be necessary to carry out this  
22 demonstration program.

23 (4) TERMINATION.—The demonstration pro-  
24 gram under this subsection shall terminate 1 year  
25 after such time as the Secretary has implemented



1 the revised risk adjustment methodology required in  
2 subsection (a).

3 (5) FUNDING.—There are authorized to be ap-  
4 propriated to the Secretary \$25,000,000 for carrying  
5 out the demonstration program under this sub-  
6 section.

7 (e) DEFINITION.—In this section, the term “special-  
8 ized programs for frail elderly and at-risk beneficiaries”  
9 means—

10 (1) demonstrations approved by the Secretary  
11 for purposes of testing the integration of acute and  
12 expanded care services under prepaid financing  
13 which include prescription drugs and other non-  
14 covered ancillary services, care coordination, and  
15 home and community-based services, such as the so-  
16 cial health maintenance organization demonstration  
17 project authorized under section 2355 of the Deficit  
18 Reduction Act of 1984 and expanded under section  
19 4207(b)(4)(B)(i) of the Omnibus Reconciliation Act  
20 of 1990;

21 (2) demonstrations approved by the Secretary  
22 for purposes of improving quality of care and pre-  
23 venting hospitalizations for nursing home residents,  
24 such as the EverCare demonstration project;

1           (3) demonstrations approved by the Secretary  
 2       for purposes of testing methods for integrating  
 3       medicare and medicaid benefits for the dually eligi-  
 4       ble, such as the Minnesota Senior Health Options  
 5       program, the Wisconsin Partnership program, the  
 6       Massachusetts Senior Care Organization program,  
 7       and the Rochester Community Care Network pro-  
 8       gram;

9           (4) demonstrations approved by the Secretary  
 10      under subsection (d); and

11          (5) such other demonstrations or programs ap-  
 12      proved by the Secretary for similar purposes, as de-  
 13      termined by the Secretary.

14 **TITLE III—DEVELOPMENT OF**  
 15 **NATIONAL POLICIES ON EF-**  
 16 **FECTIVE CHRONIC CONDI-**  
 17 **TION CARE**

18 **SEC. 301. STUDY AND REPORT ON EFFECTIVE CHRONIC**  
 19 **CONDITION CARE.**

20       (a) STUDY.—For purposes of improving chronic con-  
 21      dition care furnished to medicare beneficiaries under the  
 22      medicare program, the Secretary of Health and Human  
 23      Services shall conduct a comprehensive study of chronic  
 24      condition trends of medicare beneficiaries and associated

1 service utilization, quality indicators, and cumulative  
2 costs.

3 (b) SPECIFIC MATTERS STUDIED.—The study con-  
4 ducted under subsection (a) shall include an assessment  
5 of the following:

6 (1) Chronic condition prevalence rates.

7 (2) Demographic, medical, and functional infor-  
8 mation about medicare beneficiaries with chronic  
9 conditions.

10 (3) Utilization, cost, and quality data across  
11 settings, including—

12 (A) expenditures under a State plan under  
13 title XIX of the Social Security Act for individ-  
14 uals dually eligible for benefits under the medi-  
15 care and medicaid programs,

16 (B) data on out-of-pocket expenses paid by  
17 medicare beneficiaries,

18 (C) data on payments made by non-Fed-  
19 eral health insurance programs,

20 (D) amounts and percentages of overall  
21 payments made to medicare providers of serv-  
22 ices and suppliers for medicare beneficiaries  
23 with chronic conditions, and

1           (E) current and future cost-shifting for  
2           treatment of such beneficiaries between the  
3           medicare and medicaid programs.

4       (c) INFORMATION.—

5           (1) IN GENERAL.—The Secretary may collect  
6           such data from providers of services, suppliers, fiscal  
7           intermediaries, and carriers. Such providers, sup-  
8           pliers, fiscal intermediaries, and carriers shall fur-  
9           nish to the Secretary the data the Secretary requires  
10          to conduct the study under subsection (a).

11          (2) REQUIREMENT TO CONSIDER DATA PRE-  
12          VIOUSLY COLLECTED.—To the maximum extent  
13          practicable, in conducting the study, the Secretary  
14          shall analyze existing data and utilize existing data  
15          collection methodologies.

16          (3) CONSULTATION.—The Secretary shall con-  
17          sult with representatives of providers of services,  
18          suppliers, fiscal intermediaries, and carriers with re-  
19          spect to data collection requirements to conduct the  
20          study with respect to the specific matters described  
21          in subsection (b).

22       (d) REPORT.—

23           (1) IN GENERAL.—Not later than 3 years after  
24           the date of enactment of this Act, and triennially  
25           thereafter, the Secretary shall submit to Congress a

1 report on the study conducted under subsection (a)  
 2 and the specific matters studied under subsection  
 3 (b).

4 (2) RECOMMENDATIONS.—Each report shall  
 5 also include specific recommendations with respect  
 6 to appropriate care for medicare beneficiaries with  
 7 chronic conditions, including the establishment, and  
 8 refinement, of goals for reducing chronic condition  
 9 prevalence rates and related medical expenses.

10 (e) DEFINITION.—In this section, the term “chronic  
 11 condition” means one or more physical or mental condi-  
 12 tions which are likely to last for an unspecified period of  
 13 time, or for the duration of an individual’s life, for which  
 14 there is no known cure, and which may affect an individ-  
 15 ual’s ability to carry out basic activities of daily living,  
 16 instrumental activities of daily living, or both.

17 (f) REDUCTION OF PAPERWORK; ASSISTANCE WITH  
 18 DEVELOPMENT OF COMPUTER-ASSISTED PAPERWORK  
 19 REDUCTION TECHNOLOGY.—

20 (1) REDUCTION OF PAPERWORK.—Not later  
 21 than one year after the date of enactment of this  
 22 Act, the Secretary shall, in consultation with pro-  
 23 viders of services and suppliers under the medicare  
 24 program, patient advocacy groups, and State and  
 25 local health care administration experts, implement

1 a program to eliminate or simplify those paperwork  
2 requirements that are not required by law, and do  
3 not contribute to the quality of care furnished to  
4 medicare beneficiaries or the integrity of the medi-  
5 care program.

6 (2) DEVELOPMENT OF BEST PRACTICES SOFT-  
7 WARE.—

8 (A) IN GENERAL.—The Secretary, through  
9 the Office of Research and Development of the  
10 Center for Medicare and Medicaid Services,  
11 shall develop and disseminate to providers of  
12 services and suppliers participating in the medi-  
13 care program best practices electronic software  
14 and medical technology information systems de-  
15 signed to reduce the duplicative recording of in-  
16 formation, to reduce the need for handwritten  
17 entries, and to reduce the risk of medical and  
18 pharmaceutical errors in data entry.

19 (B) TECHNICAL ASSISTANCE.—The Sec-  
20 retary shall provide for technical assistance in  
21 the use of the electronic software developed  
22 under subparagraph (A).

23 (C) AUTHORIZATION OF APPROPRIA-  
24 TIONS.—For each of fiscal years 2002, 2003,  
25 and 2004, there are authorized to be appro-

1           priated to the Secretary \$10,000,000 to carry  
2           out this paragraph.

3 **SEC. 302. INSTITUTE OF MEDICINE MEDICARE CHRONIC**  
4                   **CONDITION CARE IMPROVEMENT STUDY AND**  
5                   **REPORT.**

6           (a) STUDY.—

7               (1) IN GENERAL.—The Secretary shall contract  
8           with the Institute of Medicine of the National Acad-  
9           emy of Sciences to—

10                   (A) conduct a comprehensive study of the  
11           medicare program to identify—

12                           (i) factors that facilitate access to ef-  
13                   fective care (including, where appropriate,  
14                   hospice care) for medicare beneficiaries  
15                   with chronic conditions; and

16                           (ii) factors that impede access to such  
17                   care for such beneficiaries,

18           including the issues studied under paragraph  
19           (2); and

20                   (B) submit the report described in sub-  
21           section (b).

22           (2) ISSUES STUDIED.—The study required  
23           under paragraph (1) shall—

24                   (A) identify inconsistent clinical, financial,  
25           or administrative requirements across provider

1 and supplier settings or professional services  
2 with respect to medicare beneficiaries;

3 (B) identify requirements under the pro-  
4 gram imposed by law or regulation that—

5 (i) promote costshifting across pro-  
6 viders and suppliers;

7 (ii) impede access to effective chronic  
8 condition care by requiring the demonstra-  
9 tion of continuing clinical improvement of  
10 the condition as a prerequisite to coverage  
11 of certain benefits;

12 (iii) impose unnecessary burdens on  
13 such beneficiaries and their family care-  
14 givers;

15 (iv) impede coverage for services that  
16 prevent, delay, or minimize the progression  
17 of chronic conditions;

18 (v) impede the establishment of ad-  
19 ministrative information systems to track  
20 health status, utilization, cost, and quality  
21 data across providers and suppliers and  
22 provider settings;

23 (vi) impede the establishment of clin-  
24 ical information systems that support con-



1                   tinuity of care across settings and over  
2                   time;

3                   (vii) impede the alignment of financial  
4                   incentives among the medicare program,  
5                   the medicaid program, and group health  
6                   plans and providers and suppliers that fur-  
7                   nish services to the same beneficiary; or

8                   (viii) impede payment methods that  
9                   encourage the enrollment of high-risk pop-  
10                  ulations, support innovation, or encourage  
11                  providers and suppliers to maintain or im-  
12                  prove health status for such medicare  
13                  beneficiaries.

14           (b) REPORT.—On the date that is 18 months after  
15 the date of enactment of this Act, the Institute of Medi-  
16 cine of the National Academy of Sciences shall submit to  
17 Congress and the Secretary of Health and Human Serv-  
18 ices a report that contains—

19                   (1) a detailed statement of the findings and  
20                   conclusions of the study conducted under subsection  
21                   (a); and

22                   (2) recommendations to improve access to effec-  
23                   tive care for medicare beneficiaries with chronic con-  
24                   ditions.

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