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.

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.

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 ''Medicare Chronic Care Improvement Act of 2001''.

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

SEC. 2. DEFINITIONS.

In this Act:

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

(2) SERIOUS AND DISABLING CHRONIC CONDITION.—The term ''serious and disabling chronic condition'' means, with respect to an individual, that the individual has at least one physical or mental condition 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.

(3) ACTIVITIES OF DAILY LIVING.—The term ''activities of daily living'' means each of the following:

(A) Eating.

(B) Toileting.

(C) Transferring.

(D) Bathing.

(E) Dressing.

(F) Continence.

(4) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ''instrumental activities of daily living'' means each of the following:

(A) Medication management.

(B) Meal preparation.

(C) Shopping.

(D) Housekeeping.

(E) Laundry.

(F) Money management.

(G) Telephone use.

(H) Transportation use.

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.

In this title:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

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

(2) COST-SAVING BENEFIT.—The term ''cost-saving benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

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

(3) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

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

(4) MEDICALLY EFFICACIOUS.—The term ''medically efficacious'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

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

SEC. 102. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR EXISTING PREVENTIVE HEALTH BENEFITS.

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

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE HEALTH ITEMS AND SERVICES.—The Secretary shall not require the payment of any deductible or coinsurance under subsection (a) or (b), respectively, of

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

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

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

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

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).

''(9) Screening for glaucoma (as defined in section 1861(uu)).

''(10) Medical nutrition therapy services (as defined in section 1861(vv)(1)).''.

(b) WAIVER OF COINSURANCE.—

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

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', preventive health items and services described in section 1833(p),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE.—Section 1833(b)(1) of the Social Security Act (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health items and services described in subsection (p),''.

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

(e) CONFORMING AMENDMENTS.—

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

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) of the Social Security Act (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows

through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections'';

(ii) by striking ''(I) in accordance'' and inserting the following:

''(i) in accordance'';

(iii) by striking ''(II) are performed'' and all that follows through ''payment under'' and inserting the following:

''(ii) are performed in an ambulatory surgical center or hospital outpatient department,

payment under''; and

(iv) by striking clause (ii); and

(B) in paragraph (3)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections''; and

(ii) by striking clause (ii).

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

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

SEC. 103. INSTITUTE OF MEDICINE MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries, including the issues described in paragraph (2); and

(B) submit the report described in subsection (b).

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

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

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

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

(B) utilization by medicare beneficiaries of such benefits (including any barriers to or incentives to increase utilization);

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

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

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

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

(b) REPORTS.—

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

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

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

(2) INTERIM REPORT BASED ON NEW GUIDELINES.—If the United States Preventive Services Task Force or the Task Force on Community Preventive Services establishes new guidelines regarding preventive health benefits for medicare beneficiaries more than 1 year prior to the date that a report described in paragraph (1) is due to be submitted to the President, then not later than 6 months after the date such new guidelines are established, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed description of such new guidelines. Such report may also contain recommendations for legislation described in paragraph (3).

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

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

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

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—Subject to paragraph (2), on the day that is 6 months after the date on which the report described in paragraph (1) of subsection (b) (or paragraph (2) of such subsection if the report contains recommendations in legislative form described in subsection (b)(3)) is submitted to the President, the President shall transmit the report and recommendations to Congress.

(2) REGULATORY ACTION BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.—If the Secretary of Health and Human Services has exercised the authority under section 104(a) to adopt by regulation one or more of the recommendations under subsection (b)(3), the President shall only submit to Congress those recommendations under subsection (b)(3) that have not been adopted by the Secretary.

(3) DELIVERY.—Copies of the report and recommendations in legislative form required to be

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

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

(B) to the Clerk of the House of Representatives if the House is not in session; and

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

SEC. 104. AUTHORITY TO ADMINISTRATIVELY PROVIDE FOR COVERAGE OF ADDITIONAL PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services may by regulation adopt any or all of the legislative recommendations developed by the Institute of Medicine of the National Academy of Sciences, in consultation with the United States Preventive Services Task Force and the Task Force on Community Preventive Services in a report under section 103(b)(3) (relating to prioritizing and modifying preventive health benefits under the medicare program and the addition of new preventive benefits), consistent with subsection (b).

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

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

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

SEC. 105. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

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

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this 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-

ate designated by the Majority Leader and Minority Leader.

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

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

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

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

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

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

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

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

Subtitle B—Expansion of Access to Health Promotion Services

SEC. 111. DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

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

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

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual who—

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

(B) is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled under part B of such title (42 U.S.C. 1395j et seq.) or is enrolled under the Medicare+Choice program under part C of such title (42 U.S.C. 1395w–21 et seq.).

(b) NUMBER; PROJECT AREAS; DURATION.—

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

(2) PROJECT AREAS.—The Secretary shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas.

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

year period beginning on the date on which the initial demonstration project is implemented.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 18 months after the conclusion of the demonstration projects under this section, the Secretary shall submit a report to Congress on such projects.

(2) CONTENTS OF REPORT.—The report required under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

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

(I) medically effective;

(II) medically efficacious;

(III) cost-effective; or

(IV) cost-saving;

(ii) the level of the disease self-management attained by target individuals under the demonstration projects; and

(iii) the satisfaction of target individuals under the demonstration projects.

(C) Recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis.

(D) Such recommendations for legislation and administrative action as the Secretary determines to be appropriate.

(E) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

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

SEC. 112. MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM.

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 HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

''SEC. 1897. (a) ESTABLISHMENT.—Not later than 18 months after the date of the conclusion of the demonstration projects conducted under subsection (b)(1), the Secretary shall establish a comprehensive and systematic

model for delivering health promotion and disease prevention services that—

''(1) through self-assessment identifies—

''(A) behavioral risk factors, such as tobacco use, physical inactivity, alcohol use, depression, lack of proper nutrition, and risk of falling, among target individuals;

''(B) needed medicare clinical preventive and screening health benefits among target individuals; and

''(C) functional and self-management information the Secretary determines to be appropriate;

''(2) provides ongoing followup to reduce risk factors and promote the appropriate use of preventive and screening health benefits;

''(3) improves clinical outcomes, satisfaction, quality of life, and appropriate use by target individuals of items and services covered under the medicare program; and

''(4) provides target individuals with information regarding the adoption of healthy behaviors.

''(b) DEMONSTRATION PROJECTS.—

''(1) ESTABLISHMENT.—Not later than 1 year 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—

"(I) questions regarding behavioral risk factors;

"(II) questions regarding needed preventive screening health services;

"(III) questions regarding the target individual's preferences for receiving follow-up information; and

"(IV) other information that the Secretary determines appropriate.

"(B) PROVISION OF INFORMATION.—After each target individual completes the self-assessment, the Secretary shall ensure that the target individual is provided with such information as the Secretary determines appropriate, which may include—

"(i) information regarding the results of the self-assessment;

"(ii) recommendations regarding any appropriate behavior modification based on the self-assessment;

"(iii) information regarding how to access behavior modification assistance that promotes healthy behavior, including information on nurse hotlines, counseling

services, provider services, and case-management services;

"(iv) information, feedback, support, and recommendations regarding any need for clinical preventive and screening health services or treatment; and

"(v) referrals to available community resources in order to assist the target individual in reducing health risks.

"(3) PROJECT AREAS AND DURATION.—

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

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

"(c) REPORT TO CONGRESS.—

"(1) IN GENERAL.—Not later than 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on such projects.

"(2) CONTENTS OF REPORT.—The report submitted under paragraph (1) shall—

"(A) describe the demonstration projects conducted under this section;

"(B) identify the demonstration project that is the most effective; and

"(C) contain such other information regarding the demonstration projects as the Secretary determines appropriate.

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

"(A) how successful the project was at—

"(i) reaching target individuals and engaging them in an assessment of the risk factors of such individuals;

"(ii) educating target individuals on healthy behaviors and getting such individuals to modify their behaviors in order to diminish the risk of chronic disease; and

"(iii) ensuring that target individuals were provided with necessary information;

"(B) the cost-effectiveness of the demonstration project; and

"(C) the degree of beneficiary satisfaction under the demonstration projects.

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

''(e) FUNDING.—There are authorized to be appropriated $25,000,000 to the Secretary for carrying out the demonstration projects under this section.

''(f) DEFINITION OF TARGET INDIVIDUAL.—The term 'target individual' means each individual who is—

''(1) entitled to benefits under part A or enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C; or

''(2) between the ages of 50 and 64 and who is not described in paragraph (1).''.

Subtitle C—Medicare Coverage for Care Coordination and Assessment Services

SEC. 121. CARE COORDINATION AND ASSESSMENT SERVICES.

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

''CARE COORDINATION AND ASSESSMENT SERVICES

''SEC. 1898. (a) PURPOSE.—The purpose of this section is to provide assistance to a beneficiary with a serious and disabling chronic condition (as defined in subsection (f)(1)) to obtain the appropriate level and mix of follow-up care.

''(b) ELECTION OF CARE COORDINATION AND ASSESSMENT SERVICES.—

''(1) IN GENERAL.—On or after January 1, 2003, a beneficiary with a serious and disabling chronic condition may elect to receive care coordination services in accordance with the provisions of this section under which, in appropriate circumstances, the eligible beneficiary has health care services covered under this title managed and coordinated by a care coordinator who is qualified under subsection (e) to furnish care coordination services under this section.

''(2) REVOCATION OF ELECTION.—An eligible beneficiary who has made an election under paragraph (1) may revoke that election at any time.

''(c) OUTREACH.—The Secretary shall provide for the wide dissemination of information to beneficiaries and providers of services, physicians, practitioners, and suppliers

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

''(d) CARE COORDINATION AND ASSESSMENT SERVICES DESCRIBED.—Care coordination services under this section shall include the following:

''(1) BASIC CARE COORDINATION AND ASSESSMENT SERVICES.—

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

''(i)(I) An initial assessment of an individual's medical condition, functional and cognitive capacity, and environmental and psychosocial needs.

''(II) Annual assessments after the initial assessment performed under subclause (I), unless the physician or care coordinator of the individual determines that additional assessments are required due to sentinel health events or changes in the health status of the individual that may require changes in plans of care developed for the individual.

''(ii) The development of an initial plan of care, and subsequent appropriate revisions to that plan of care.

''(iii) The management of, and referral for, medical and other health services, including multidisciplinary care conferences and coordination with other providers.

''(iv) The monitoring and management of medications.

''(v) Patient education and counseling services.

''(vi) Family caregiver education and counseling services.

''(vii) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(viii) Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergency consultations.

''(ix) Coordination with the principal nonprofessional caregiver in the home.

''(x) Managing and facilitating transitions among health care professionals and across settings of care, including the following:

''(I) Pursuing the treatment option elected by the individual.

''(II) Including any advance directive executed by the individual in the medical file of the individual.

''(xi) Activities that facilitate continuity of care and patient adherence to plans of care.

''(xii) Information about, and referral to, hospice services, including patient and family caregiver education and counseling about hospice, and facilitating transition to hospice when elected.

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

''(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to eligible beneficiaries who have made an election under this section (subject to an assessment by the care coordinator of an individual beneficiary's circumstances and need for such benefits) in order to encourage the receipt of, or to improve the effectiveness of, care coordination services.

''(2) CARE COORDINATION AND ASSESSMENT REQUIREMENT.—Notwithstanding any other provision of this title, with respect to items and services for which payment is made under this title furnished to a beneficiary for the diagnosis and treatment of the beneficiary's serious and disabling chronic condition, if the beneficiary has made an election to receive care coordination and assessment services under this section, the Secretary may require that payment may only be made under this title for such items and services relating to such condition if the items and services have been furnished by or coordinated through the care coordinator. Under such provision, the Secretary shall prescribe exceptions for emergency medical services (as described in section

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

''(e) CARE COORDINATORS.—

''(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination and assessment services under this section, an individual or entity shall—

''(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

''(B) enter into a care coordination agreement under paragraph (2); and

''(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

''(2) AGREEMENT TERM; PAYMENT.—

''(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall—

''(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1);

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

''(iii) contain such other terms and conditions as the Secretary may require.

''(B) PAYMENT FOR SERVICES.—The Secretary shall establish payment terms and conditions and payment rates for basic care coordination and assessment services described in subsection (d)(1). The Secretary may establish new billing codes to carry out the provisions of this subparagraph.

''(f) DEFINITIONS.—In this section:

''(1) SERIOUS AND DISABLING CHRONIC CONDITION.—The term 'serious and disabling chronic condition' means, with respect to an individual, that the 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.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(3) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' means each of the following:

''(A) Medication management.

''(B) Meal preparation.

''(C) Shopping.

''(D) Housekeeping.

''(E) Laundry.

''(F) Money management.

''(G) Telephone use.

''(H) Transportation use.

''(4) BENEFICIARY.—The term 'beneficiary' means an individual entitled to benefits under part A, or enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C.''.

(b) COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

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

(B) in the first sentence—

(i) by striking ''and'' at the end of paragraph (14);

(ii) by striking the period at the end of paragraph (15) and inserting ''; and''; and

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

''(16) care coordination and assessment services furnished by a care coordinator in accordance with section 1866C.''.

(2) CONFORMING AMENDMENTS.—Sections 1864(a) 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are each amended by striking ''paragraphs (16) and (17)'' each place it appears and inserting ''clauses (i) and (ii) of the second sentence''.

(3) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO CARE COORDINATION AND ASSESSMENT SERVICES.—

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

(i) by striking ''and'' at the end of subparagraph (T); and

(ii) by inserting before the final semicolon '', and (V) with respect to care coordination and assessment services described in section 1861(s)(16) that are furnished by, or coordinated through, a care coordinator, the amounts paid shall be 100 percent of the payment amount established under section 1866C''.

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

(i) by striking ''and'' at the end of paragraph (5); and

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

sessment services (as described in section 1861(s)(16))''.

(C) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)), as amended by section 102(b)(2), is further amended by inserting after ''section 1833(p),'' the following: ''with respect to care coordination and assessment services (as described in section 1861(s)(16)),''.

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

SEC. 201. ADJUSTMENTS TO FEE-FOR-SERVICE PAYMENT SYSTEMS.

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

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

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

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

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

(3) The prospective payment system for outpatient hospital services under section 1833(t) of such Act (42 U.S.C. 1395l(t)).

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

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

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

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

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

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

(d) PATIENT CLASSIFICATION SYSTEM.—The Secretary shall develop a patient classification system or other methodology to predict costs within and across postacute care settings attributable to furnishing items and services to medicare beneficiaries who suffer from serious and disabling chronic conditions. The Secretary shall develop such system by not later than October 1, 2004, and shall consult with representatives of providers of services and individuals with expertise in health care financing and risk adjustment methodology in developing such system.

SEC. 202. MEDICARE+CHOICE.

(a) REVISIONS TO RISK ADJUSTMENT METHODOLOGY.—

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

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

(A) hybrid risk adjustment payment systems, such as partial capitation;

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

(C) improving the structural components of the applicable method of payment, such as reducing payment lag, using multiple site diagnostic data, and using several years of data;

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

(E) testing concurrent risk adjustment methodologies; and

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

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

(4) INTERIM REPORT.—Not later than January 1, 2004, the Secretary shall submit to Congress a report on revision of the risk adjustment methodology required under paragraph (1), including a description of the methods considered and employed by the Secretary in providing for such revision and an assessment of the impacts of such methods on access to effective care for medicare beneficiaries.

(b) INTERIM CONTINUATION OF BLENDED RATE FOR SPECIALIZED PROGRAMS FOR FRAIL ELDERLY AND AT-RISK MEDICARE BENEFICIARIES RESIDING IN INSTITUTIONS.—

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

institutions or beneficiaries that are entitled to medical assistance under a State plan under title XIX, notwithstanding section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(3)(C)(ii)), such organization shall be paid according to the method described in section 1853(a)(3)(C)(ii)(I) until such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.—A Medicare+Choice organization may not qualify for the payment methodology under paragraph (1) unless the organization collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(c) INTERIM CONTINUATION OF PAYMENT METHODOLOGIES FOR DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, payment methodologies for medicare demonstration programs for specialized programs for frail elderly and at-risk beneficiaries that comply with the requirements under paragraph (2) shall continue under the terms and conditions of the

demonstration authority, including the risk adjustment factors and formula used for paying such demonstration programs, until such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.—A medicare demonstration program may not qualify for the payment methodology under paragraph (1) unless the program collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(d) INTERIM DEMONSTRATION PROGRAM FOR ADDITIONAL PAYMENTS FOR SPECIALIZED PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program under which additional payments (in such manner and amount as the Secretary determines appropriate) may be made to a Medicare+Choice organization that complies with the requirements under paragraph (2) and that offers a Medicare+Choice plan that—

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

with serious and disabling chronic conditions; and

(B) exclusively serves enrollees with serious and disabling chronic conditions or serves a disproportionate share of such enrollees.

(2) REQUIREMENTS.—A Medicare+Choice organization may not qualify for additional payments under paragraph (1) unless the organization and the specialized program of care meet the following requirements:

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

(i) methods to prevent, delay, or minimize the progression of disabilities;

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

(iii) appropriate specially trained health care staff, such as nurse practitioners, geriatric care managers, or mental health professionals; and

(iv) methods for promoting integration of care, financing, and administrative functions across health care settings.

(B) The organization collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(C) The organization employs quality standards and tracks quality indicators specified by the Secretary that are relevant to the special needs of enrollees with serious and disabling chronic conditions.

(D) The organization does not receive payments, or adjustment to payments, with respect to any enrollee by reason of subsection (b) or (c).

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

(4) TERMINATION.—The demonstration program under this subsection shall terminate 1 year after such time as the Secretary has implemented

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

(5) FUNDING.—There are authorized to be appropriated to the Secretary $25,000,000 for carrying out the demonstration program under this subsection.

(e) DEFINITION.—In this section, the term ''specialized programs for frail elderly and at-risk beneficiaries'' means—

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

(2) demonstrations approved by the Secretary for purposes of improving quality of care and preventing hospitalizations for nursing home residents, such as the EverCare demonstration project;

(3) demonstrations approved by the Secretary for purposes of testing methods for integrating medicare and medicaid benefits for the dually eligible, such as the Minnesota Senior Health Options program, the Wisconsin Partnership program, the Massachusetts Senior Care Organization program, and the Rochester Community Care Network program;

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

(5) such other demonstrations or programs approved by the Secretary for similar purposes, as determined by the Secretary.

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

SEC. 301. STUDY AND REPORT ON EFFECTIVE CHRONIC CONDITION CARE.

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

service utilization, quality indicators, and cumulative costs.

(b) SPECIFIC MATTERS STUDIED.—The study conducted under subsection (a) shall include an assessment of the following:

(1) Chronic condition prevalence rates.

(2) Demographic, medical, and functional information about medicare beneficiaries with chronic conditions.

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

(A) expenditures under a State plan under title XIX of the Social Security Act for individuals dually eligible for benefits under the medicare and medicaid programs,

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

(C) data on payments made by non-Federal health insurance programs,

(D) amounts and percentages of overall payments made to medicare providers of services and suppliers for medicare beneficiaries with chronic conditions, and

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

(c) INFORMATION.—

(1) IN GENERAL.—The Secretary may collect such data from providers of services, suppliers, fiscal intermediaries, and carriers. Such providers, suppliers, fiscal intermediaries, and carriers shall furnish to the Secretary the data the Secretary requires to conduct the study under subsection (a).

(2) REQUIREMENT TO CONSIDER DATA PREVIOUSLY COLLECTED.—To the maximum extent practicable, in conducting the study, the Secretary shall analyze existing data and utilize existing data collection methodologies.

(3) CONSULTATION.—The Secretary shall consult with representatives of providers of services, suppliers, fiscal intermediaries, and carriers with respect to data collection requirements to conduct the study with respect to the specific matters described in subsection (b).

(d) REPORT.—

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

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

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

(e) DEFINITION.—In this section, the term ''chronic condition'' means one or more physical or mental conditions which are likely to last for an unspecified period of time, or for the duration of an individual's life, for which there is no known cure, and which may affect an individual's ability to carry out basic activities of daily living, instrumental activities of daily living, or both.

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

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

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

(2) DEVELOPMENT OF BEST PRACTICES SOFTWARE.—

(A) IN GENERAL.—The Secretary, through the Office of Research and Development of the Center for Medicare and Medicaid Services, shall develop and disseminate to providers of services and suppliers participating in the medicare program best practices electronic software and medical technology information systems designed to reduce the duplicative recording of information, to reduce the need for handwritten entries, and to reduce the risk of medical and pharmaceutical errors in data entry.

(B) TECHNICAL ASSISTANCE.—The Secretary shall provide for technical assistance in the use of the electronic software developed under subparagraph (A).

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

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

SEC. 302. INSTITUTE OF MEDICINE MEDICARE CHRONIC CONDITION CARE IMPROVEMENT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to—

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

(i) factors that facilitate access to effective care (including, where appropriate, hospice care) for medicare beneficiaries with chronic conditions; and

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

including the issues studied under paragraph (2); and

(B) submit the report described in subsection (b).

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

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

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

(B) identify requirements under the program imposed by law or regulation that—

(i) promote costshifting across providers and suppliers;

(ii) impede access to effective chronic condition care by requiring the demonstration of continuing clinical improvement of the condition as a prerequisite to coverage of certain benefits;

(iii) impose unnecessary burdens on such beneficiaries and their family caregivers;

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

(v) impede the establishment of administrative information systems to track health status, utilization, cost, and quality data across providers and suppliers and provider settings;

(vi) impede the establishment of clinical information systems that support con-

tinuity of care across settings and over time;

(vii) impede the alignment of financial incentives among the medicare program, the medicaid program, and group health plans and providers and suppliers that furnish services to the same beneficiary; or

(viii) impede payment methods that encourage the enrollment of high-risk populations, support innovation, or encourage providers and suppliers to maintain or improve health status for such medicare beneficiaries.

(b) REPORT.—On the date that is 18 months after the date of enactment of this Act, the Institute of Medicine of the National Academy of Sciences shall submit to Congress and the Secretary of Health and Human Services a report that contains—

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

(2) recommendations to improve access to effective care for medicare beneficiaries with chronic conditions.

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