

108TH CONGRESS
1ST SESSION

H. R. 2342

To amend title XVIII of the Social Security Act to expand Medicare benefits to prevent, delay, and minimize the progression of chronic conditions, and develop national policies on effective chronic condition care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 2003

Mr. STARK (for himself, Mr. RANGEL, Mr. MATSUI, Mr. McDERMOTT, Mr. SANDLIN, and Mrs. JONES of Ohio) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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, 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,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Chronic Care Improvement Act of 2003”.

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

Sec. 1. Short title; table of contents.

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

Subtitle A—Improving Access to Preventive Services

Sec. 101. Elimination of deductibles and coinsurance for existing preventive health benefits.

Sec. 102. Institute of Medicine medicare prevention benefit study and report.

Sec. 103. Authority to administratively provide for coverage of additional preventive benefits.

Sec. 104. Coverage of an initial preventive physical examination.

Subtitle B—Medicare Coverage for Care Coordination and Assessment Services

Sec. 111. Care coordination and assessment services.

Sec. 112. Care coordination and assessment services and quality improvement program in Medicare+Choice plans.

Sec. 113. Improving chronic care coordination through information technology.

Subtitle C—Additional Provisions

Sec. 121. Review of coverage standards.

TITLE II—INSTITUTE OF MEDICINE STUDY ON EFFECTIVE
CHRONIC CONDITION CARE

Sec. 201. Institute of Medicine medicare chronic condition care improvement study and report.

1 **TITLE I—BENEFITS TO PRE-**
2 **VENT, DELAY, AND MINIMIZE**
3 **THE PROGRESSION OF**
4 **CHRONIC CONDITIONS**

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

7 **SEC. 101. ELIMINATION OF DEDUCTIBLES AND COINSUR-**
8 **ANCE FOR EXISTING PREVENTIVE HEALTH**
9 **BENEFITS.**

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

13 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR
14 PREVENTIVE HEALTH ITEMS AND SERVICES.—The Sec-
15 retary shall not require the payment of any deductible or
16 coinsurance under subsection (a) or (b), respectively, of
17 any individual enrolled for coverage under this part for
18 any of the following preventive health items and services:

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

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

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

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

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

9 “(6) Bone mass measurement (as defined in
10 section 1861(rr)(1)).

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

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

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

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

19 (b) WAIVER OF COINSURANCE.—

20 (1) IN GENERAL.—Section 1833(a)(1)(B) of the
21 Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is
22 amended to read as follows: “(B) with respect to
23 preventive health items and services described in
24 subsection (p), the amounts paid shall be 100 per-

1 cent of the fee schedule or other basis of payment
2 under this title for the particular item or service,”.

3 (2) ELIMINATION OF COINSURANCE IN OUT-
4 PATIENT HOSPITAL SETTINGS.—The third sentence
5 of section 1866(a)(2)(A) of the Social Security Act
6 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-
7 ing after “1861(s)(10)(A)” the following: “, preven-
8 tive health items and services described in section
9 1833(p),”.

10 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—
11 Section 1833(b)(1) of the Social Security Act (42 U.S.C.
12 1395l(b)(1)) is amended to read as follows: “(1) such de-
13 ductible shall not apply with respect to preventive health
14 items and services described in subsection (p),”.

15 (d) ADDING “LANCET” TO DEFINITION OF DME.—
16 Section 1861(n) of the Social Security Act (42 U.S.C.
17 1395x(n)) is amended by striking “blood-testing strips
18 and blood glucose monitors” and inserting “blood-testing
19 strips, lancets, and blood glucose monitors”.

20 (e) CONFORMING AMENDMENTS.—

21 (1) ELIMINATION OF COINSURANCE FOR CLIN-
22 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs
23 (1)(D)(i) and (2)(D)(i) of section 1833(a) of the So-
24 cial Security Act (42 U.S.C. 1395l(a)) are each

1 amended by inserting “or which are described in
2 subsection (p)” after “assignment-related basis”.

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

9 (3) ELIMINATION OF DEDUCTIBLES AND COIN-
10 SURANCE FOR COLORECTAL CANCER SCREENING
11 TESTS.—Section 1834(d) of the Social Security Act
12 (42 U.S.C. 1395m(d)) is amended—

13 (A) in paragraph (2)(C)—

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

18 “(C) FACILITY PAYMENT LIMIT.—Notwith-
19 standing subsections”;

20 (ii) by striking “(I) in accordance”
21 and inserting the following:

22 “(i) in accordance”;

23 (iii) by striking “(II) are performed”
24 and all that follows through “payment
25 under” and inserting the following:

1 “(ii) are performed in an ambulatory
2 surgical center or hospital outpatient de-
3 partment,

4 payment under”; and

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

6 (B) in paragraph (3)(C)—

7 (i) by striking “(C) FACILITY PAY-
8 MENT LIMIT.—” and all that follows
9 through “Notwithstanding subsections”
10 and inserting the following:

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

13 (ii) by striking clause (ii).

14 (f) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished on or after
16 January 1, 2004.

17 **SEC. 102. INSTITUTE OF MEDICINE MEDICARE PREVEN-**
18 **TION BENEFIT STUDY AND REPORT.**

19 (a) STUDY.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services shall contract with the Institute of
22 Medicine of the National Academy of Sciences to—

23 (A) conduct a comprehensive study of cur-
24 rent literature and best practices in the field of
25 health promotion and disease prevention among

1 medicare beneficiaries, including the issues de-
2 scribed in paragraph (2); and

3 (B) submit the report described in sub-
4 section (b).

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

8 (A) whether each health promotion and
9 disease prevention benefit covered under the
10 medicare program is medically effective (as de-
11 fined in subsection (d)(3));

12 (B) utilization by medicare beneficiaries of
13 such benefits (including any barriers to or in-
14 centives to increase utilization);

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

17 (D) whether health promotion and disease
18 prevention benefits that are not covered under
19 the medicare program that would affect all
20 medicare beneficiaries are likely to be medically
21 effective (as so defined).

22 (b) REPORTS.—

23 (1) THREE-YEAR REPORT.—On the date that is
24 3 years after the date of enactment of this Act, and
25 each successive 3-year anniversary thereafter, the

1 Institute of Medicine of the National Academy of
2 Sciences shall submit to the President a report that
3 contains—

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

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

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

23 (3) RECOMMENDATIONS FOR LEGISLATION.—
24 The Institute of Medicine of the National Academy
25 of Sciences, in consultation with the United States

1 Preventive Services Task Force and the Task Force
2 on Community Preventive Services, shall develop
3 recommendations in legislative form that—

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

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

9 (c) TRANSMISSION TO CONGRESS.—

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

18 (2) REGULATORY ACTION BY THE SECRETARY
19 OF HEALTH AND HUMAN SERVICES.—If the Sec-
20 retary of Health and Human Services has exercised
21 the authority under section 103(a) to adopt by regu-
22 lation one or more of the recommendations under
23 subsection (b)(3), the President shall only submit to
24 Congress those recommendations under subsection
25 (b)(3) that have not been adopted by the Secretary.

1 (3) DELIVERY.—Copies of the report and rec-
2 ommendations in legislative form required to be
3 transmitted to Congress under paragraph (1) shall
4 be delivered—

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

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

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

11 (d) DEFINITION OF MEDICALLY EFFECTIVE.—In
12 this section, the term “medically effective” means, with
13 respect to a benefit or technique, that the benefit or tech-
14 nique has been—

15 (1) subject to peer review;

16 (2) described in scientific journals; and

17 (3) determined to achieve an intended goal
18 under normal programmatic conditions.

19 **SEC. 103. AUTHORITY TO ADMINISTRATIVELY PROVIDE**
20 **FOR COVERAGE OF ADDITIONAL PREVEN-**
21 **TIVE BENEFITS.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services may by regulation adopt any or all of
24 the legislative recommendations developed by the Institute
25 of Medicine of the National Academy of Sciences, in con-

1 sultation with the United States Preventive Services Task
2 Force and the Task Force on Community Preventive Serv-
3 ices in a report under section 102(b)(3) (relating to
4 prioritizing and modifying preventive health benefits
5 under the medicare program and the addition of new pre-
6 ventive benefits), consistent with subsection (b).

7 (b) **ELIMINATION OF COST-SHARING.**—With respect
8 to items and services furnished under the medicare pro-
9 gram that the Secretary has incorporated by regulation
10 under subsection (a), the provisions of section 1833(p) of
11 the Social Security Act (relating to elimination of cost-
12 sharing for preventive benefits), as added by section
13 101(a), shall apply to those items and services in the same
14 manner as such section applies to the items and services
15 described in paragraphs (1) through (10) of such section.

16 **SEC. 104. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**
17 **ICAL EXAMINATION.**

18 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
19 curity Act (42 U.S.C. 1395x(s)(2)) is amended—

20 (1) in subparagraph (U), by striking “and” at
21 the end;

22 (2) in subparagraph (V), by inserting “and” at
23 the end; and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 “(W) an initial preventive physical examination
2 (as defined in subsection (ww));”.

3 (b) SERVICES DESCRIBED.—Section 1861 of such
4 Act (42 U.S.C. 1395x) is amended by adding at the end
5 the following new subsection:

6 “Initial Preventive Physical Examination

7 “(ww) The term ‘initial preventive physical examina-
8 tion’ means physicians’ services consisting of a physical
9 examination with the goal of health promotion and disease
10 detection and includes a history and physical exam, a
11 health risk appraisal, and health risk counseling, and lab-
12 oratory tests or other items and services as determined
13 by the Secretary in consultation with the United States
14 Preventive Services Task Force.”.

15 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

16 (1) DEDUCTIBLE.—The first sentence of sec-
17 tion 1833(b) of such Act (42 U.S.C. 1395l(b)) is
18 amended—

19 (A) by striking “and” before “(6)”, and

20 (B) by inserting before the period at the
21 end the following: “, and (7) such deductible
22 shall not apply with respect to an initial preven-
23 tive physical examination (as defined in section
24 1861(ww))”.

1 (2) COINSURANCE.—Section 1833(a)(1) of such
2 Act (42 U.S.C. 1395l(a)(1)) is amended—

3 (A) in clause (N), by inserting “(or 100
4 percent in the case of an initial preventive phys-
5 ical examination, as defined in section
6 1861(ww))” after “80 percent”; and

7 (B) in clause (O), by inserting “(or 100
8 percent in the case of an initial preventive phys-
9 ical examination, as defined in section
10 1861(ww))” after “80 percent”.

11 (d) PAYMENT AS PHYSICIANS’ SERVICES.—Section
12 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is
13 amended by inserting “(2)(W),” after “(2)(S),”.

14 (e) OTHER CONFORMING AMENDMENTS.—Section
15 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

16 (1) in paragraph (1)—

17 (A) by striking “and” at the end of sub-
18 paragraph (H);

19 (B) by striking the semicolon at the end of
20 subparagraph (I) and inserting “, and”; and

21 (C) by adding at the end the following new
22 subparagraph:

23 “(J) in the case of an initial preventive physical
24 examination (as defined in section 1861(ww)), which
25 is performed not later than 6 months after the date

1 the individual's first coverage period begins under
2 part B;"; and

3 (2) in paragraph (7), by striking "or (H)" and
4 inserting "(H), or (J)".

5 (f) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to services furnished on or after
7 January 1, 2004, but only for individuals whose coverage
8 period begins on or after such date.

9 **Subtitle B—Medicare Coverage for**
10 **Care Coordination and Assess-**
11 **ment Services**

12 **SEC. 111. CARE COORDINATION AND ASSESSMENT SERV-**
13 **ICES.**

14 (a) SERVICES AUTHORIZED.—Title XVIII of the So-
15 cial Security Act (42 U.S.C. 1395 et seq.) is amended by
16 adding at the end the following new section:

17 "CARE COORDINATION AND ASSESSMENT SERVICES

18 "SEC. 1897. (a) PURPOSE.—

19 "(1) IN GENERAL.—The purpose of this section
20 is to provide the appropriate level and mix of follow-
21 up care to an individual with a chronic condition
22 who qualifies as an eligible beneficiary (as defined in
23 paragraph (2)).

24 "(2) ELIGIBLE BENEFICIARY DEFINED.—In
25 this section, the term 'eligible beneficiary' means a
26 beneficiary who—

1 “(A) has a serious and disabling chronic
2 condition (as defined in subsection(f)(1)); or

3 “(B) has four or more chronic conditions
4 (as defined in subsection (f)(4)).

5 “(b) ELECTION OF CARE COORDINATION AND AS-
6 SESSMENT SERVICES.—

7 “(1) IN GENERAL.—On or after January 1,
8 2005, an eligible beneficiary may elect to receive
9 care coordination services in accordance with the
10 provisions of this section under which, in appro-
11 priate circumstances, the eligible beneficiary has
12 health care services covered under this title managed
13 and coordinated by a care coordinator who is quali-
14 fied under subsection (e) to furnish care coordina-
15 tion services under this section.

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

19 “(c) OUTREACH.—The Secretary shall provide for the
20 wide dissemination of information to beneficiaries and pro-
21 viders of services, physicians, practitioners, and suppliers
22 with respect to the availability of and requirements for
23 care coordination services under this section.

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

4 “(1) BASIC CARE COORDINATION AND ASSESS-
5 MENT SERVICES.—Except as otherwise provided in
6 this section, eligible beneficiaries who have made an
7 election under this section shall receive the following
8 services:

9 “(A)(i) An initial assessment of an individ-
10 ual’s medical condition, functional and cognitive
11 capacity, and environmental and psychosocial
12 needs.

13 “(ii) Annual assessments after the initial
14 assessment performed under clause (i), unless
15 the physician or care coordinator of the indi-
16 vidual determines that additional assessments
17 are required due to sentinel health events or
18 changes in the health status of the individual
19 that may require changes in the plan of care
20 developed for the individual.

21 “(B) The development of an initial plan of
22 care, and subsequent appropriate revisions to
23 that plan of care.

24 “(C) The management of, and referral for,
25 medical and other health services, including

1 multidisciplinary care conferences and coordina-
2 tion with other providers.

3 “(D) The monitoring and management of
4 medications.

5 “(E) Patient education and counseling
6 services.

7 “(F) Family caregiver education and coun-
8 seling services.

9 “(G) Self-management services, including
10 health education and risk appraisal to identify
11 behavioral risk factors through self-assessment.

12 “(H) Consultations by telephone with phy-
13 sicians and other appropriate health care pro-
14 fessionals, including 24-hour access to a care
15 coordinator.

16 “(I) Coordination with the principal care-
17 giver in the home.

18 “(J) The managing and facilitating of
19 transitions among health care professionals and
20 across settings of care, including the following:

21 “(i) The pursuit the treatment option
22 elected by the individual.

23 “(ii) The inclusion of any advance di-
24 rective executed by the individual in the
25 medical file of the individual.

1 “(K) Activities that facilitate continuity of
2 care and patient adherence to plans of care.

3 “(L) Information about, and referral to,
4 community-based services, including patient and
5 family caregiver education and counseling about
6 such services, and facilitating access to such
7 services when elected.

8 “(M) Information about, and referral to,
9 hospice services and palliative care, including
10 patient and family caregiver education and
11 counseling about hospice services and palliative
12 care, and facilitating transition to hospice when
13 elected.

14 “(N) Such other medical and health care
15 services for which payment would not otherwise
16 be made under this title as the Secretary deter-
17 mines to be appropriate for effective care co-
18 ordination, including the additional items and
19 services as described in paragraph (2).

20 “(2) ADDITIONAL BENEFITS.—The Secretary
21 may specify additional benefits for which payment
22 would not otherwise be made under this title that
23 may be available to eligible beneficiaries who have
24 made an election under this section (subject to an
25 assessment by the care coordinator of an individual

1 beneficiary's circumstances and need for such bene-
2 fits) in order to encourage the receipt of, or to im-
3 prove the effectiveness of, care coordination services.

4 “(e) CARE COORDINATORS.—

5 “(1) REQUIREMENT FOR CERTIFICATION.—

6 “(A) IN GENERAL.—In order to be quali-
7 fied to furnish care coordination and assess-
8 ment services under this section, an individual
9 or entity shall be a health care professional or
10 entity (which may include physicians, physician
11 group practices, or other health care profes-
12 sionals or entities the Secretary may find ap-
13 propriate) who has been certified for a period
14 (as provided in subparagraph (B)) by the Sec-
15 retary, or by an organization recognized by the
16 Secretary, as having met such criteria as the
17 Secretary may establish for the furnishing of
18 care coordination under this section (which may
19 include experience in the provision of care co-
20 ordination or primary care physician's services).

21 “(B) PERIOD OF CERTIFICATION.—The pe-
22 riod of certification for an individual referred to
23 in subparagraph (A) is as follows:

1 “(i) A one-year period for each of the
2 first three years of participation under this
3 section.

4 “(ii) A three-year period thereafter.

5 “(2) ADDITIONAL REQUIREMENTS.—

6 “(A) SUBMISSION OF DATA.—A care coordi-
7 nator shall comply with such data collection
8 and reporting requirements as the Secretary de-
9 termines necessary to assess the effect of care
10 coordination on health outcomes.

11 “(B) PARTICIPATION IN QUALITY IM-
12 PROVEMENT PROGRAM.—A care coordinator
13 shall participate in the quality improvement
14 program under paragraph (3).

15 “(C) ADDITIONAL TERMS.—A care coordi-
16 nator shall comply with such other terms and
17 conditions as the Secretary may specify.

18 “(3) QUALITY IMPROVEMENT PROGRAM.—

19 “(A) IN GENERAL.—The Secretary shall
20 establish a chronic care quality assurance pro-
21 gram to monitor and improve clinical outcomes
22 for beneficiaries with chronic conditions.

23 “(B) ELEMENTS OF PROGRAM.—Under the
24 program, the Secretary shall—

25 “(i) establish standards to measure—

1 “(I) quality and performance of
2 the care of chronic conditions;

3 “(II) the continuity and coordi-
4 nation of care that eligible bene-
5 ficiaries under this section receive;
6 and

7 “(III) both underutilization and
8 overutilization of services;

9 “(ii) provide to care coordinators peri-
10 odic reports on their performance on such
11 measures; and

12 “(iii) make available information on
13 quality and outcomes measures to facilitate
14 beneficiary comparison and choice of care
15 coordination options (in such form and on
16 such quality and outcomes measures as the
17 Secretary determines to be appropriate).

18 “(C) REVIEW OF CLAIMS.—

19 “(i) IN GENERAL.—Subject to clause
20 (ii), under the program the Secretary shall
21 make available to care coordinators claims
22 data relating to a beneficiary for whom the
23 coordinator coordinates care under this
24 section for the coordinator’s review and
25 subsequent appropriate follow-up action.

1 “(ii) AUTHORIZATION.—Data may
2 only be provided to a care coordinator
3 under clause (i) if the eligible beneficiary
4 involved has given written authorization
5 for such information to be so provided.

6 “(4) LIMITATION ON NUMBER OF CARE COOR-
7 DINATORS.—Payment may only be made under this
8 section for care coordination services furnished dur-
9 ing a period to one care coordinator with respect to
10 an eligible beneficiary.

11 “(5) PAYMENT FOR SERVICES.—

12 “(A) IN GENERAL.—The Secretary shall
13 establish payment terms and conditions and
14 payment rates for basic care coordination and
15 assessment services described in subsection (d).

16 “(B) PAYMENT METHODOLOGY.—Payment
17 under this section shall be made in a manner
18 that bundles payment for all care coordination
19 and assessment services furnished during a pe-
20 riod, as specified by the Secretary.

21 “(C) CODES.—The Secretary may estab-
22 lish new billing codes to carry out the provisions
23 of this paragraph.

24 “(f) DEFINITIONS.—In this section:

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

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

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

13 or

14 “(ii) such number of instrumental ac-
15 tivities of daily living that is equivalent (as
16 determined by the Secretary) to the level
17 of disability described in clause (i);

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

22 “(C) the individual requires substantial su-
23 pervision to protect the individual from threats
24 to health and safety due to severe cognitive im-
25 pairment.

1 “(2) ACTIVITIES OF DAILY LIVING.—The term
2 ‘activities of daily living’ means each of the fol-
3 lowing:

4 “(A) Eating.

5 “(B) Toileting.

6 “(C) Transferring.

7 “(D) Bathing.

8 “(E) Dressing.

9 “(F) Continence.

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

13 “(A) Medication management.

14 “(B) Meal preparation.

15 “(C) Shopping.

16 “(D) Housekeeping.

17 “(E) Laundry.

18 “(F) Money management.

19 “(G) Telephone use.

20 “(H) Transportation use.

21 “(4) CHRONIC CONDITION.—The term ‘chronic
22 condition’ means an illness, functional limitation, or
23 cognitive impairment that—

24 “(A) lasts, or is expected to last, at least
25 one year;

1 “(B) limits what a person can do; and

2 “(C) requires on-going medical care.

3 “(5) BENEFICIARY.—The term ‘beneficiary’
4 means an individual entitled to benefits under part
5 A and enrolled under part B, including an individual
6 enrolled under the Medicare+Choice program under
7 part C.”.

8 (b) COVERAGE OF CARE COORDINATION AND AS-
9 SESSMENT SERVICES AS A PART B MEDICAL SERVICE.—

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

12 (A) in the second sentence, by redesignig-
13 nating paragraphs (16) and (17) as clauses (i)
14 and (ii); and

15 (B) in the first sentence—

16 (i) by striking “and” at the end of
17 paragraph (14);

18 (ii) by striking the period at the end
19 of paragraph (15) and inserting “; and”;
20 and

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

23 “(16) care coordination and assessment services
24 furnished by a care coordinator in accordance with
25 section 1897.”.

1 (2) CONFORMING AMENDMENTS.—Sections
2 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of
3 such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and
4 1396n(a)(1)(B)(ii)(I)) are each amended by striking
5 “paragraphs (16) and (17)” each place it appears
6 and inserting “clauses (i) and (ii) of the second sen-
7 tence”.

8 (3) PART B COINSURANCE AND DEDUCTIBLE
9 NOT APPLICABLE TO CARE COORDINATION AND AS-
10 SESSMENT SERVICES.—

11 (A) COINSURANCE.—Section 1833(a)(1) of
12 the Social Security Act (42 U.S.C. 1395l(a)(1))
13 is amended—

14 (i) by striking “and” at the end of
15 subparagraph (T); and

16 (ii) by inserting before the final semi-
17 colon “, and (V) with respect to care co-
18 ordination and assessment services de-
19 scribed in section 1861(s)(16) that are fur-
20 nished by, or coordinated through, a care
21 coordinator, the amounts paid shall be 100
22 percent of the payment amount established
23 under section 1897”.

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

1 (i) by striking “and” at the end of
2 paragraph (5); and

3 (ii) by inserting before the final period
4 “, and (7) such deductible shall not apply
5 with respect to care coordination and as-
6 sessment services (as described in section
7 1861(s)(16))”.

8 (C) ELIMINATION OF COINSURANCE IN
9 OUTPATIENT HOSPITAL SETTINGS.—The third
10 sentence of section 1866(a)(2)(A) of such Act
11 (42 U.S.C. 1395cc(a)(2)(A)), as amended by
12 section 101(b)(2), is further amended by insert-
13 ing after “section 1833(p),” the following:
14 “with respect to care coordination and assess-
15 ment services (as described in section
16 1861(s)(16))”.

17 **SEC. 112. CARE COORDINATION AND ASSESSMENT SERV-**
18 **ICES AND QUALITY IMPROVEMENT PROGRAM**
19 **IN MEDICARE+CHOICE PLANS.**

20 Section 1852(e)(1) of the Social Security Act (42
21 U.S.C. 1395w-22(e)(1)) is amended by inserting before
22 the period at the end the following: “, including a quality
23 improvement program for coordinated care services re-
24 ferred to in section 1897(e)(3)”.

1 **SEC. 113. IMPROVING CHRONIC CARE COORDINATION**
2 **THROUGH INFORMATION TECHNOLOGY.**

3 (a) **TECHNOLOGY IMPROVEMENT GRANTS.**—

4 (1) **IN GENERAL.**—The Secretary of Health and
5 Human Services (hereinafter in this section referred
6 to as the “Secretary”) shall make grants to eligible
7 entities to enable such entities to develop, imple-
8 ment, or train personnel in the use of standardized
9 clinical information technology systems designed
10 to—

11 (A) improve the coordination and quality
12 of care furnished to medicare beneficiaries with
13 chronic conditions; and

14 (B) increase administrative efficiencies of
15 such entities.

16 (2) **CARE COORDINATORS AS ELIGIBLE ENTI-**
17 **TIES.**—In this section, an eligible entity is a care co-
18 ordinator who furnishes care coordination services to
19 medicare beneficiaries under section 1897 of the So-
20 cial Security Act.

21 (b) **ELIGIBILITY.**—To be eligible to receive a grant
22 under subsection (a), a care coordinator shall—

23 (1) prepare and submit to the Secretary an ap-
24 plication at such time, in such manner, and con-
25 taining such information as the Secretary may re-
26 quire, including a description of the clinical informa-

1 tion technology system that the care coordinator in-
2 tends to implement using amounts received under
3 the grant;

4 (2) provide assurances that are satisfactory to
5 the Secretary that such system, for which amounts
6 are to be expended under the grant, conforms to the
7 standards established by the Secretary under part C
8 of title XI of the Social Security Act, and such other
9 standards as the Secretary may specify; and

10 (3) furnish the Secretary with such information
11 as the Secretary may require to—

12 (A) evaluate the project for which the
13 grant is made; and

14 (B) ensure that funding provided under
15 the grant is expended for the purposes for
16 which it is made.

17 (c) MATCHING REQUIREMENT.—The Secretary may
18 not make a grant to a care coordinator under subsection
19 (a) unless that care coordinator agrees that, with respect
20 to the costs to be incurred by the care coordinator in car-
21 rying out the activities for which the grant is being award-
22 ed, the care coordinator will make available (directly or
23 through donations from public or private entities) non-
24 Federal contributions toward such costs in an amount

1 equal to \$1 for each \$1 of Federal funds provided under
2 the grant.

3 (d) REPORTS TO CONGRESS.—

4 (1) INITIAL REPORT.—Not later than 18
5 months after the first grant has been made under
6 this section, the Secretary shall submit an initial re-
7 port to Congress containing the information referred
8 to in paragraph (3) as well as any recommendations
9 with respect to grants under this section.

10 (2) FINAL REPORT.—Not later than 6 months
11 after the last grant has been awarded (as deter-
12 mined by the Secretary) under this section, the Sec-
13 retary shall submit a final report to Congress con-
14 taining the information referred to in paragraph (2)
15 as well as any recommendations with respect to
16 grants under this section.

17 (3) CONTENTS OF REPORT.—The reports under
18 this subsection shall include the following:

19 (A) A description of the number and na-
20 ture of grants made under this section.

21 (B) An evaluation of—

22 (i) improvements in the coordination
23 and quality of care furnished to bene-
24 ficiaries with chronic conditions; and

1 (ii) increases in administrative effi-
2 ciencies of care coordinators.

3 (e) AUTHORIZATION OF APPROPRIATIONS.—For each
4 of fiscal years 2005, 2006, and 2007, there are authorized
5 to be appropriated to the Secretary \$10,000,000 to carry
6 out the program under this section.

7 **Subtitle C—Additional Provisions**

8 **SEC. 121. REVIEW OF COVERAGE STANDARDS.**

9 (a) REVIEW.—With respect to determinations under
10 section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1))
11 (relating to whether an item or service is reasonable and
12 necessary for the diagnosis or treatment of illness or in-
13 jury for purposes of payment under title XVIII of such
14 Act), the Secretary of Health and Human Services shall
15 conduct a review of—

16 (1) regulations, policies, procedures, and in-
17 structions of the Centers for Medicare & Medicaid
18 Services for making those determinations; and

19 (2) policies, procedures, local medical review
20 policies, manual instructions, interpretative rules,
21 statements of policy, and guidelines of general appli-
22 cability of fiscal intermediaries (under section 1816
23 of the Social Security Act (42 U.S.C. 1395h)) and
24 carriers under section 1842 of such Act (42 U.S.C.
25 1395u) for making those determinations.

1 (b) MODIFICATION.—Insofar as the Secretary deter-
2 mines that the Centers for Medicare & Medicaid Services,
3 a fiscal intermediary, or a carrier has misapplied such
4 standard by requiring that the item or service improve the
5 condition of the patient with respect to such illness or in-
6 jury, the Secretary shall take such corrective measures as
7 are appropriate to ensure the Centers, intermediary, or
8 carrier (as the case may be) applies the proper standard
9 for making such determinations.

10 (c) REPORT.—On the date that is 18 months after
11 the date of enactment of this Act, the Secretary shall sub-
12 mit to Congress a report that contains—

13 (1) a detailed statement of the findings and
14 conclusions of the review conducted under subsection
15 (a);

16 (2) a detailed statement of the modifications
17 made under subsection (b); and

18 (3) recommendations to avoid misapplication of
19 the standard in the future.

1 **TITLE II—INSTITUTE OF MEDI-**
2 **CINE STUDY ON EFFECTIVE**
3 **CHRONIC CONDITION CARE**

4 **SEC. 201. INSTITUTE OF MEDICINE MEDICARE CHRONIC**
5 **CONDITION CARE IMPROVEMENT STUDY AND**
6 **REPORT.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall contract with the Institute of
10 Medicine of the National Academy of Sciences to—

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

13 (i) factors that facilitate provision of
14 effective care (including, where appro-
15 priate, hospice care) for medicare bene-
16 ficiaries with chronic conditions; and

17 (ii) factors that impede provision of
18 such care for such beneficiaries,
19 including the issues studied under paragraph
20 (2); and

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

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

1 (A) identify inconsistent clinical, financial,
2 or administrative requirements across provider
3 and supplier settings or professional services
4 with respect to medicare beneficiaries;

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

7 (i) promote costshifting across pro-
8 viders and suppliers;

9 (ii) impede provision of effective,
10 seamless transitions across health care set-
11 tings, such as between hospitals, skilled
12 nursing facilities, home health services,
13 hospice care, and care in the home;

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

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

22 (v) impede the establishment of clin-
23 ical information systems that support con-
24 tinuity of care across settings and over
25 time; or

1 (vi) impede the alignment of financial
2 incentives among the medicare program,
3 the medicaid program, and group health
4 plans and providers and suppliers that fur-
5 nish services to the same beneficiary.

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

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

14 (2) recommendations to improve provision of ef-
15 fective care for medicare beneficiaries with chronic
16 conditions.

○