

108TH CONGRESS
2D SESSION

H. R. 4689

To amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to geriatric assessments and chronic care management, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 2004

Mr. GREEN of Texas (for himself, Mr. HINCHEY, Mr. RANGEL, Mr. FROST, Mr. GUTIERREZ, and Mr. ENGEL) 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 provide Medicare beneficiaries with access to geriatric assessments and chronic care management, 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 “Geriatric and Chronic Care Management Act of 2004”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Medicare coverage of geriatric assessments.
- Sec. 4. Medicare coverage of chronic care management services.
- Sec. 5. Study and report on best practices for medicare chronic care management.

3 **SEC. 2. FINDINGS.**

4 Congress makes the following findings:

5 (1) We must redesign the medicare system to
 6 provide high-quality, cost-effective care to a growing
 7 population: elderly individuals with multiple chronic
 8 conditions.

9 (2) According to the Congressional Budget Of-
 10 fice, 50 percent of medicare costs can be attributed
 11 to 5 percent of medicare's most costly beneficiaries.

12 (3) Currently, 82 percent of the medicare popu-
 13 lation has at least 1 chronic condition, and $\frac{2}{3}$ have
 14 more than 1 chronic condition. The 20 percent of
 15 beneficiaries with 5 or more chronic conditions ac-
 16 count for $\frac{2}{3}$ of all medicare spending. In addition,
 17 the large Baby Boomer generation is moving toward
 18 retirement and medicare eligibility.

19 (4) In general, the prevalence of chronic condi-
 20 tions increases with age: 74 percent of the 65- to
 21 69-year-old group have a least 1 chronic condition,
 22 while 86 percent of the 85 years and older group

1 have at least 1 chronic condition. Similarly, just 14
2 percent of the 65- to 69-year-olds have 5 or more
3 chronic conditions, but 28 percent of the 85 years
4 and older group have 5 or more chronic conditions.

5 (5) There is a strong pattern of increasing utili-
6 zation as the number of conditions increase. Fifty-
7 five percent of medicare beneficiaries with 5 or more
8 conditions experienced an inpatient hospital stay
9 compared to 5 percent for those with 1 condition or
10 9 percent for those with 2 conditions.

11 (6) In terms of physician visits, the average
12 medicare beneficiary has over 15 physician visits an-
13 nually and sees 6 different physicians annually.

14 (7) There is almost a 4-fold increase in visits by
15 people with 5 chronic conditions compared to visits
16 by people with 1 chronic condition. The number of
17 specific physicians seen increases almost 2½ times
18 for people with 5 or more chronic conditions relative
19 to those with just 1 chronic condition.

20 (8) When Alzheimer's disease and dementia are
21 present along with 1 or more other chronic condi-
22 tions, utilization also increases. For example, in
23 2000, total average per person medicare expendi-
24 tures for those with congestive heart failure and Alz-
25 heimer's or dementia were 47 percent higher than

1 for those with congestive heart failure and no de-
2 mentia.

3 (9) Based on numerous studies in the United
4 States and internationally, we know that the delivery
5 of higher quality health care, increased efficiency
6 and cost-effectiveness are the result of systems in
7 which patients are linked with a physician or other
8 qualified health professional who coordinates their
9 care.

10 (10) The current medicare program penalizes
11 physicians for integrating and coordinating health
12 care because these services are not explicitly recog-
13 nized and distinctly paid for. Instead, physicians are
14 incentivized to provide episodic care and to generate
15 more individual patient visits to the doctor's office
16 and hospital for separately reimbursed tests and
17 procedures.

18 (11) The chronic care model established by this
19 Act includes several elements that are effective in
20 managing chronic disease—

21 (A) linkages with community resources;

22 (B) health care system changes that re-
23 ward quality chronic care;

24 (C) support for patient self-management of
25 chronic disease;

1 (D) practice redesign;

2 (E) evidence-based clinical practice guide-
3 lines; and

4 (F) clinical information systems, such as
5 electronic medical records and continuity of
6 care records.

7 (12) We must realign the financial incentives
8 within medicare as part of a comprehensive system
9 change. Medicare should be restructured to reim-
10 burse physicians and other qualified health profes-
11 sionals for the cost of coordinating care.

12 **SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESS-**
13 **MENTS.**

14 (a) PART B COVERAGE OF GERIATRIC ASSESS-
15 MENTS.—

16 (1) IN GENERAL.—Section 1861(s)(2) of the
17 Social Security Act (42 U.S.C. 1395x(s)(2)), as
18 amended by section 642(a) of the Medicare Prescrip-
19 tion Drug, Improvement, and Modernization Act of
20 2003 (Public Law 108–173; 117 Stat. 2322), is
21 amended—

22 (A) in subparagraph (Y), by striking
23 “and” after the semicolon at the end;

24 (B) in subparagraph (Z), by adding “and”
25 after the semicolon at the end; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(AA) geriatric assessments (as defined in sub-
4 section (bbb)(1)).”.

5 (2) CONFORMING AMENDMENTS.—(A) Section
6 1862(a)(7) of the Social Security Act (42 U.S.C.
7 1395y(a)(7)), as amended by section 611(d)(1)(B)
8 of the Medicare Prescription Drug, Improvement,
9 and Modernization Act of 2003 (Public Law 108–
10 173; 117 Stat. 2304), is amended by striking “or
11 (K)” and inserting “(K), or (AA)”.

12 (B) Clauses (i) and (ii) of section
13 1861(s)(2)(K) of the Social Security Act (42 U.S.C.
14 1395x(s)(2)(K)), as amended by section 611(d)(2) of
15 the Medicare Prescription Drug, Improvement, and
16 Modernization Act of 2003 (Public Law 108–173;
17 117 Stat. 2304), are each amended by striking
18 “subsection (ww)(1)” and inserting “subsections
19 (ww)(1) and (bbb)(1)”.

20 (b) GERIATRIC ASSESSMENTS DEFINED.—Section
21 1861 of the Social Security Act (42 U.S.C. 1395x), as
22 amended by section 706(b) of the Medicare Prescription
23 Drug, Improvement, and Modernization Act of 2003 (Pub-
24 lic Law 108–173; 117 Stat. 2339), is amended by adding
25 at the end the following new subsection:

1 “Geriatric Assessment; Eligible Individual

2 “(bbb)(1) The term ‘geriatric assessment’ means—

3 “(A) an initial assessment of an eligible individ-
4 ual’s medical condition, functional and cognitive ca-
5 pacity, primary caregiver needs, and environmental
6 and psychosocial needs that is conducted by a physi-
7 cian or an entity that meets such conditions as the
8 Secretary may specify (which may include physi-
9 cians, physician group practices, or other health care
10 professionals or entities the Secretary may find ap-
11 propriate) working in collaboration with a physician;
12 and

13 “(B) subsequent assessments, which may not be
14 conducted more frequently than annually, unless a
15 physician or chronic care manager of the eligible in-
16 dividual determines that such assessments are re-
17 quired due to sentinel health events or changes in
18 the health status of the individual that may require
19 changes in plans of care developed for the individual.

20 “(2)(A) For purposes of this subsection, the term ‘eli-
21 gible individual’ means an individual who has—

22 “(i) at least 5 chronic conditions and an inabil-
23 ity to manage care (as defined by the Secretary); or

24 “(ii) a mental or cognitive impairment, includ-
25 ing dementia, and at least 1 other chronic condition.

1 “(B) For purposes of this paragraph, the term
 2 ‘chronic condition’ means an illness, functional limitation,
 3 or cognitive impairment that is expected to last at least
 4 1 year, limits the activities of an individual, and requires
 5 ongoing care.”.

6 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
 7 ING.—

8 (1) PAYMENT AND ELIMINATION OF COINSUR-
 9 ANCE.—Section 1833(a)(1) of the Social Security
 10 Act (42 U.S.C. 1395l(a)(1)), as amended by section
 11 302(b)(2) of the Medicare Prescription Drug, Im-
 12 provement, and Modernization Act of 2003 (Public
 13 Law 108–173; 117 Stat. 2229), is amended—

14 (A) in subparagraph (N), by inserting
 15 “other than geriatric assessments (as defined in
 16 section 1861(bbb)(1))” after “(as defined in
 17 section 1848(j)(3))”;

18 (B) by striking “and” before “(V)”; and

19 (C) by inserting before the semicolon at
 20 the end the following: “, and (W) with respect
 21 to geriatric assessments (as defined in section
 22 1861(bbb)(1)), the amount paid shall be 100
 23 percent of the lesser of the actual charge for
 24 the services or the amount determined under

1 the payment basis determined under section
2 1848”.

3 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-
4 ULE.—Section 1848(j)(3) of the Social Security Act
5 (42 U.S.C. 1395w-4(j)(3)), as amended by section
6 611(c) of the Medicare Prescription Drug, Improve-
7 ment, and Modernization Act of 2003 (Public Law
8 108–173; 117 Stat. 2304), is amended by inserting
9 “(2)(AA),” after “(2)(W),”.

10 (3) ELIMINATION OF COINSURANCE IN OUT-
11 PATIENT HOSPITAL SETTINGS.—

12 (A) EXCLUSION FROM OPD FEE SCHED-
13 ULE.—Section 1833(t)(1)(B)(iv) of the Social
14 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as
15 amended by section 614 of the Medicare Pre-
16 scription Drug, Improvement, and Moderniza-
17 tion Act of 2003 (Public Law 108–173; 117
18 Stat. 2306), is amended by striking “and diag-
19 nostic mammography” and inserting “, diag-
20 nostic mammography, or geriatric assessments
21 (as defined in section 1861(bbb)(1))”.

22 (B) CONFORMING AMENDMENTS.—Section
23 1833(a)(2) of the Social Security Act (42
24 U.S.C. 1395l(a)(2)) is amended—

1 (i) in subparagraph (F), by striking
2 “and” after the semicolon at the end;

3 (ii) in subparagraph (G)(ii), by strik-
4 ing the comma at the end and inserting “;
5 and”; and

6 (iii) by inserting after subparagraph
7 (G)(ii) the following new subparagraph:

8 “(H) with respect to geriatric assessments
9 (as defined in section 1861(bbb)(1)) furnished
10 by an outpatient department of a hospital, the
11 amount determined under paragraph (1)(W),”.

12 (4) ELIMINATION OF DEDUCTIBLE.—The first
13 sentence of section 1833(b) of the Social Security
14 Act (42 U.S.C. 1395l(b)) is amended—

15 (A) by striking “and” before “(6)”; and

16 (B) by inserting before the period the fol-
17 lowing: “, and (7) such deductible shall not
18 apply with respect to geriatric assessments (as
19 defined in section 1861(bbb)(1))”.

20 (d) FREQUENCY LIMITATION.—Section 1862(a)(1) of
21 the Social Security Act (42 U.S.C. 1395y(a)(1)), as
22 amended by section 613(c) of the Medicare Prescription
23 Drug, Improvement, and Modernization Act of 2003 (Pub-
24 lic Law 108–173; 117 Stat. 2306), is amended—

1 (1) by striking “and” at the end of subpara-
2 graph (L);

3 (2) by striking the semicolon at the end of sub-
4 paragraph (M) and inserting “, and”; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(N) in the case of geriatric assessments (as
8 defined in section 1861(bbb)(1)), which are per-
9 formed more frequently than is covered under such
10 section;”.

11 (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
12 RALS.—Section 1877(b) of the Social Security Act (42
13 U.S.C. 1395nn(b)), as amended by section 101(e)(8)(B)
14 of the Medicare Prescription Drug, Improvement, and
15 Modernization Act of 2003 (Public Law 108–173; 117
16 Stat. 2306), is amended by adding at the end the following
17 new paragraph:

18 “(6) GERIATRIC ASSESSMENTS.—In the case of
19 a designated health service, if the designated health
20 service is a geriatric assessment (as defined in sec-
21 tion 1861(bbb)(1)) and furnished by a physician.”.

22 (f) RULEMAKING.—The Secretary of Health and
23 Human Services shall define such terms and establish
24 such procedures as the Secretary determines necessary to
25 implement the provisions of this section.

1 (g) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to assessments and chronic care
 3 management services furnished on or after January 1,
 4 2005.

5 **SEC. 4. MEDICARE COVERAGE OF CHRONIC CARE MANAGE-**
 6 **MENT SERVICES.**

7 (a) PART B COVERAGE OF CHRONIC CARE MANAGE-
 8 MENT SERVICES.—

9 (1) IN GENERAL.—Section 1861(s)(2) of the
 10 Social Security Act (42 U.S.C. 1395x(s)(2)), as
 11 amended by section 3(a)(1), is amended—

12 (A) in subparagraph (Z), by striking
 13 “and” after the semicolon at the end;

14 (B) in subparagraph (AA), by adding
 15 “and” after the semicolon at the end; and

16 (C) by adding at the end the following new
 17 subparagraph:

18 “(BB) chronic care management services (as
 19 defined in subsection (ccc));”.

20 (2) CONFORMING AMENDMENTS.—(A) Section
 21 1862(a)(7) of the Social Security Act (42 U.S.C.
 22 1395y(a)(7)), as amended section 3(a)(2)(A), is
 23 amended by striking “or (AA)” and inserting “(AA),
 24 or (BB)”.

1 (B) Clauses (i) and (ii) of section
2 1861(s)(2)(K) of the Social Security Act (42 U.S.C.
3 1395x(s)(2)(K)), as amended by section 3(a)(2)(B),
4 are each amended by striking “subsections (ww)(1)
5 and (bbb)” and inserting “subsections (ww)(1),
6 (bbb), and (ccc)”.

7 (b) SERVICES DESCRIBED.—Section 1861 of the So-
8 cial Security Act (42 U.S.C. 1395x), as amended by sec-
9 tion 3(b), is amended by adding at the end the following
10 new subsection:

11 “Chronic Care Management Services; Chronic Care
12 Manager; Eligible Individual

13 “(ccc)(1) The term ‘chronic care management serv-
14 ices’ means services that are furnished to an eligible indi-
15 vidual (as defined in paragraph (3)) by a chronic care
16 manager (as defined in paragraph (2)) under a plan of
17 care prescribed by such chronic care manager for the pur-
18 pose of chronic care management, which may include any
19 of the following services:

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

23 “(B) The management of, and referral for,
24 medical and other health services, including multi-

1 disciplinary care conferences and management with
2 other providers.

3 “(C) The monitoring and management of medi-
4 cations.

5 “(D) Patient education and counseling services.

6 “(E) Family caregiver education and counseling
7 services.

8 “(F) Self-management services, including
9 health education and risk appraisal to identify be-
10 havioral risk factors through self-assessment.

11 “(G) Providing access for consultations by tele-
12 phone with physicians and other appropriate health
13 care professionals, including 24-hour availability of
14 such professionals for emergency consultations.

15 “(H) Management with the principal nonprofes-
16 sional caregiver in the home.

17 “(I) Managing and facilitating transitions
18 among health care professionals and across settings
19 of care, including the following:

20 “(i) Pursuing the treatment option elected
21 by the individual.

22 “(ii) Including any advance directive exe-
23 cuted by the individual in the medical file of the
24 individual.

1 “(J) Information about, and referral to, hospice
2 services, including patient and family caregiver edu-
3 cation and counseling about hospice, and facilitating
4 transition to hospice when elected.

5 “(K) Information about, referral to, and man-
6 agement with, community services.

7 “(L) Such additional services for which pay-
8 ment would not otherwise be made under this title
9 that the Secretary may specify that encourage the
10 receipt of, or to improve the effectiveness of, the
11 services described in the preceding subparagraphs.

12 “(2)(A) For purposes of this subsection, the term
13 ‘chronic care manager’ means an individual or entity
14 that—

15 “(i) is—

16 “(I) a physician (as defined in subsection
17 (r)(1)); or

18 “(II) a practitioner described in section
19 1842(b)(18)(C) or an entity that meets such
20 conditions as the Secretary may specify (which
21 may include physicians, physician group prac-
22 tices, or other health care professionals or enti-
23 ties the Secretary may find appropriate) work-
24 ing in collaboration with a physician;

1 “(ii) has entered into a chronic care manage-
2 ment agreement with the Secretary; and

3 “(iii) meets such other criteria as the Secretary
4 may establish (which may include experience in the
5 provision of chronic care management or primary
6 care physicians’ services).

7 “(B) For purposes of subparagraph (A)(ii), each
8 chronic care management agreement shall—

9 “(i) be entered into for a period of 1 year and
10 may be renewed if the Secretary is satisfied that the
11 chronic care manager continues to meet the condi-
12 tions of participation specified in subparagraph (A);

13 “(ii) ensure that the chronic care manager will
14 submit reports to the Secretary on the functional
15 and medical status of eligible individuals who receive
16 chronic care management services, expenditures re-
17 lating to such services, and health outcomes relating
18 to such services, except that the Secretary may not
19 require a chronic care manager to submit more than
20 one such report during a year; and

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

23 “(3) For purposes of this subsection, the term ‘eligi-
24 ble individual’ means an eligible individual (as defined in
25 subsection (bbb)(2)) who has undergone a geriatric assess-

1 ment (as defined in subsection (bbb)(1)) and who a physi-
 2 cian has determined would benefit from chronic care man-
 3 agement.”.

4 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
 5 ING.—

6 (1) PAYMENT AND ELIMINATION OF COINSUR-
 7 ANCE.—Section 1833(a)(1) of the Social Security
 8 Act (42 U.S.C. 1395l(a)(1)), as amended by section
 9 3(c)(1), is amended—

10 (A) in subparagraph (N), by inserting “or
 11 chronic care management services (as defined in
 12 section 1861(ccc))” after “other than geriatric
 13 assessments (as defined in section
 14 1861(bbb)(1))”;

15 (B) by striking “and” before “(W)”;

16 (C) by inserting before the semicolon at
 17 the end the following: “, and (X) with respect
 18 to chronic care management services (as de-
 19 fined in section 1861(ccc)), the amount paid
 20 shall be 100 percent of the amount determined
 21 under section 1834(n)”.

22 (2) PAYMENT.—Section 1834 of the Social Se-
 23 curity Act (42 U.S.C. 1395m) is amended by adding
 24 at the end the following new subsection:

1 “(n) PAYMENT FOR CHRONIC CARE MANAGEMENT
2 SERVICES.—

3 “(1) IN GENERAL.—The Secretary shall pay for
4 chronic care management services (as defined in sec-
5 tion 1861(ccc)(1)) furnished to an eligible individual
6 (as defined in section 1861(ccc)(3)) by a chronic
7 care manager (as defined in section 1861(ccc)(2))—

8 “(A) separately from geriatric assessments
9 (as defined in section 1861(bbb)(1)) and other
10 services for which payment is made under this
11 title; and

12 “(B) based on the methodology selected by
13 the chronic care manager (as so defined) from
14 among the methodologies developed and imple-
15 mented by the Secretary under paragraph (2).

16 “(2) DEVELOPMENT AND IMPLEMENTATION OF
17 PAYMENT METHODOLOGIES.—The Secretary, in con-
18 sultation with national membership associations rep-
19 resenting physicians, qualified health professionals,
20 and patients, shall develop and implement payment
21 methodologies applicable with respect to chronic care
22 management services (as defined in section
23 1861(ccc)(1)) as follows:

24 “(A) UNADJUSTED MONTHLY CAPITATED
25 PAYMENT AMOUNT.—A per patient per month

1 chronic care management fee separate from
2 evaluation and management services for which
3 payment is made under the physician fee sched-
4 ule under section 1848 that does not take into
5 account the severity of the eligible individual's
6 condition.

7 “(B) ADJUSTED MONTHLY CAPITATED
8 PAYMENT AMOUNT.—A per patient per month
9 chronic care management fee separate from
10 evaluation and management services for which
11 payment is made under the physician fee sched-
12 ule under section 1848 that provides for an ad-
13 justment to the payment amount based on the
14 severity of the eligible individual's condition.

15 “(C) UNADJUSTED FEE SCHEDULE
16 AMOUNT.—A chronic care management fee for
17 care coordination that includes payment for re-
18 lated evaluation and management services for
19 which payment would otherwise be made under
20 the physician fee schedule under section 1848
21 that does not take into account the severity of
22 the eligible individual's condition.

23 “(D) ADJUSTED FEE SCHEDULE
24 AMOUNT.—A chronic care management fee for
25 care coordination that includes payment for re-

lated evaluation and management services for which payment would otherwise be made under the physician fee schedule under section 1848 that provides for an adjustment to the payment amount based on the severity of the eligible individual's condition.

“(E) OTHER PAYMENT METHODOLOGIES.—Any other payment methodology that the Secretary determines effective in creating incentives for physicians and other chronic care managers to make practice-based improvements to improve the quality and cost-effectiveness of care provided to eligible individuals.”.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 3(c)(3)(A), is amended by striking “or geriatric assessments (as defined in section 1861(bbb)(1))” and inserting “geriatric assessments (as defined in section 1861(bbb)(1)), or chronic care management services (as defined in section 1861(ccc)(1))”.

1 (B) CONFORMING AMENDMENTS.—Section
2 1833(a)(2) of the Social Security Act (42
3 U.S.C. 1395l(a)(2)) is amended—

4 (i) in subparagraph (G)(ii), by strik-
5 ing “and” after the semicolon at the end;

6 (ii) in subparagraph (H), by striking
7 the comma at the end and inserting “;
8 and”; and

9 (iii) by inserting after subparagraph
10 (H) the following new subparagraph:

11 “(I) with respect to chronic care manage-
12 ment services (as defined in section
13 1861(ccc)(1)) furnished by an outpatient de-
14 partment of a hospital, the amount determined
15 under section 1834(n),”.

16 (4) ELIMINATION OF DEDUCTIBLE.—Section
17 1833(b)(7) of the Social Security Act (42 U.S.C.
18 1395l(b)(7)), as added by section 3(c)(4), is amend-
19 ed by inserting “or chronic care management serv-
20 ices (as defined in section 1861(ccc)(1))” after
21 “geriatric assessments (as defined in section
22 1861(bbb)(1))”.

23 (d) APPLICATION OF LIMITS ON BILLING.—Section
24 1842(b)(18)(C) of the Social Security Act (42 U.S.C.

1 1395u(b)(18)(C)) is amended by adding at the end the
2 following new clause:

3 “(vii) A chronic care manager (as defined in
4 section 1861(ccc)(2)) that is not a physician.”.

5 (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
6 RALS.—Section 1877(b)(6) of the Social Security Act (42
7 U.S.C. 1395nn(b)(6)), as amended by section 3(e), is
8 amended to read as follows:

9 “(6) GERIATRIC ASSESSMENTS AND CHRONIC
10 CARE MANAGEMENT SERVICES.—In the case of a
11 designated health service, if the designated health
12 service is—

13 “(A) a geriatric assessment or a chronic
14 care management service (as defined in sub-
15 sections (bbb)(1) or (ccc)(1) of section 1861,
16 respectively); and

17 “(B) provided by a physician or a chronic
18 care manager (as defined in section
19 1861(ccc)(2)).”.

20 (f) RULEMAKING.—The Secretary of Health and
21 Human Services shall define such terms and establish
22 such procedures as the Secretary determines necessary to
23 implement the provisions of this section.

24 (g) EFFECTIVE DATE.—The amendments made by
25 this section shall apply to assessments and chronic care

1 management services furnished on or after January 1,
2 2005.

3 **SEC. 5. STUDY AND REPORT ON BEST PRACTICES FOR**
4 **MEDICARE CHRONIC CARE MANAGEMENT.**

5 (a) STUDY.—The Secretary, in consultation with the
6 Medicare Payment Advisory Commission, shall conduct a
7 thorough study of the following issues:

8 (1) The effectiveness of the different payment
9 methodologies applicable with respect to chronic care
10 management services developed and implemented
11 under section 1834(n)(2) of the Social Security Act
12 (as added by section 4(c)(2)).

13 (2) The effectiveness of pay-for-performance
14 programs to serve medicare beneficiaries with mul-
15 tiple chronic conditions, including dementia.

16 (3) Process measures and outcomes for medi-
17 care beneficiaries with multiple chronic illnesses, in-
18 cluding dementia.

19 (4) The cost-effectiveness and quality associated
20 with chronic care management under the medicare
21 program.

22 (5) The feasibility of broadening and incor-
23 porating the findings of the Assessing Care of Vul-
24 nerable Elders (ACOVE) study into the medicare
25 program.

1 (b) REPORT.—Not later than the date that is 1 year
2 after the date of enactment of this Act, the Secretary of
3 Health and Human Services shall submit to Congress a
4 report on the study conducted under subsection (a) that
5 contains—

6 (1) recommendations on the best practices for
7 chronic care management of the conditions of medi-
8 care beneficiaries with multiple chronic conditions,
9 including dementia; and

10 (2) such other recommendations for legislation
11 or administrative action as the Secretary determines
12 appropriate.

○