

113TH CONGRESS
1ST SESSION

H. R. 1074

To amend the Public Health Service Act to foster more effective implementation and coordination of clinical care for people with pre-diabetes and diabetes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 2013

Mr. OLSON (for himself, Mr. MORAN, Mr. SESSIONS, Mr. ROE of Tennessee, Mr. MAFFEI, and Ms. TSONGAS) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to foster more effective implementation and coordination of clinical care for people with pre-diabetes and diabetes.

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.**

4 This Act may be cited as the “National Diabetes
5 Clinical Care Commission Act”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

8 (1) The Centers for Disease Control and Pre-
9 vention report that nearly 26,000,000 Americans

1 have diabetes in addition to an estimated
2 79,000,000 American adults that have pre-diabetes,
3 an increase of 2,000,000 Americans with diabetes
4 and 22,000,000 American adults with pre-diabetes
5 since 2008.

6 (2) Diabetes affects 8.3 percent of Americans of
7 all ages and 11.3 percent of adults age 20 and older.
8 Individuals of racial and ethnic minorities continue
9 to have higher rates of diabetes than individuals not
10 of such minorities, as demonstrated by the following:
11 16.1 percent of all adult American Indians and Alas-
12 kan Natives have diabetes; 12.6 percent of all adult
13 African-Americans have diabetes; 11.8 percent of all
14 adult Hispanics have diabetes; and 8.4 percent of all
15 adult Asian-Americans have diabetes, while 7.1 per-
16 cent of all non-Hispanic Whites have diabetes.

17 (3) Diabetes is the seventh leading cause of
18 death in the United States.

19 (4) People with diabetes are more likely than
20 people without diabetes to have heart attacks,
21 strokes, high blood pressure, kidney failure, blind-
22 ness, and require amputations.

23 (5) Total national costs associated with diabetes
24 in 2007 exceeded \$174,000,000,000, according to
25 the Centers for Disease Control and Prevention.

1 (6) One in three Medicare dollars is currently
2 spent on people with diabetes.

3 (7) The Centers for Disease Control and Pre-
4 vention projects that as many as 1 in 3 American
5 adults could have diabetes by 2050 if current trends
6 continue.

7 (8) There are 35 Federal departments, agen-
8 cies, and offices involved in the implementation of
9 Federal diabetes activities.

10 **SEC. 3. ESTABLISHMENT OF THE NATIONAL DIABETES**
11 **CLINICAL CARE COMMISSION.**

12 Part P of title III of the Public Health Service Act
13 (42 U.S.C. 280g et seq.) is amended by adding at the end
14 the following new section:

15 **“SEC. 399V-6. NATIONAL DIABETES CLINICAL CARE COM-**
16 **MISSION.**

17 “(a) ESTABLISHMENT.—There is hereby established
18 within the Department of Health and Human Services the
19 National Diabetes Clinical Care Commission (in this sec-
20 tion referred to as the ‘Commission’) to evaluate and make
21 recommendations regarding better coordination and
22 leveraging of programs within the Department of Health
23 and Human Services and other Federal agencies that re-
24 late in any way to supporting appropriate clinical care
25 (such as any interactions between physicians and other

1 health care providers and their patients with pre-diabetes
2 and diabetes where care is rendered for the management
3 of their pre-diabetes or diabetes or its complications) for
4 people with pre-diabetes and diabetes.

5 “(b) MEMBERSHIP.—

6 “(1) IN GENERAL.—The Commission shall be
7 composed of the following voting members:

8 “(A) The heads (or their designees) of the
9 following Federal agencies and departments
10 that conduct programs that could impact the
11 clinical care of people with pre-diabetes and dia-
12 betes:

13 “(i) The Centers for Medicare and
14 Medicaid Services.

15 “(ii) The Agency for Healthcare Re-
16 search and Quality.

17 “(iii) The Centers for Disease Control
18 and Prevention.

19 “(iv) The Indian Health Service.

20 “(v) The Department of Veterans Af-
21 fairs.

22 “(vi) The National Institutes of
23 Health.

24 “(vii) The Food and Drug Adminis-
25 tration.

1 “(viii) The Health Resources and
2 Services Administration.

3 “(ix) The Department of Defense.

4 “(x) Other governmental or non-
5 governmental agency heads, at the discre-
6 tion of the agency, that impact clinical
7 care of individuals with pre-diabetes and
8 diabetes.

9 “(B) Twelve additional voting members ap-
10 pointed under paragraph (2).

11 “(2) ADDITIONAL MEMBERS.—The Commission
12 shall include additional voting members appointed by
13 the Comptroller General of the United States, in
14 consultation with national medical societies and pa-
15 tient advocate organizations with expertise in diabe-
16 tes and the care of patients with diabetes, including
17 one or more from each of the following categories:

18 “(A) Clinical endocrinologists.

19 “(B) Physician specialties (other than as
20 described in subparagraph (A)) that play a role
21 in diabetes care or their complications.

22 “(C) Primary care physicians.

23 “(D) Non-physician health care profes-
24 sionals, such as certified diabetes educators,

1 clinical dieticians, nurses, nurse practitioners,
2 and physician assistants.

3 “(E) Patient advocates.

4 “(F) National experts in the duties listed
5 under subsection (c).

6 “(3) CHAIRPERSON.—The voting members of
7 the Commission shall select a chairperson from the
8 members described in paragraph (2)(A).

9 “(4) MEETINGS.—The Commission shall meet
10 at least twice, and not more than 4 times, a year.

11 “(5) BOARD TERMS.—Members of the Commis-
12 sion, including the chairperson, shall serve for a 3-
13 year term. A vacancy on the Commission shall be
14 filled in the same manner as the original appoint-
15 ments.

16 “(c) DUTIES.—The Commission shall—

17 “(1) evaluate programs of the Department of
18 Health and Human Services regarding the utiliza-
19 tion of diabetes screening benefits, annual wellness
20 visits, and other preventive health benefits that may
21 reduce the risk of diabetes and its complications, ad-
22 dressing any existing problems regarding such utili-
23 zation and related data collection mechanisms;

24 “(2) identify current activities and critical gaps
25 in Federal efforts to support clinicians in providing

1 integrated, high-quality care to people with pre-dia-
2 betes and diabetes;

3 “(3) make recommendations regarding the co-
4 ordination of clinically based activities that are being
5 supported by the Federal Government;

6 “(4) make recommendations regarding the de-
7 velopment and coordination of federally funded clin-
8 ical practice support tools for physicians and other
9 health care professionals in caring for and managing
10 the care of people with pre-diabetes and diabetes;

11 “(5) evaluate programs in existence as of the
12 date of the enactment of this section and determine
13 if such programs are meeting the needs identified in
14 paragraph (2) and, if such programs are determined
15 to not be meeting such needs, recommend programs
16 that would be more appropriate;

17 “(6) recommend how an outcomes-based reg-
18 istry may be developed and then used to evaluate
19 various care models and methods and the impact of
20 such models and methods on diabetes management
21 as measured by appropriate care parameters (such
22 as A1C, blood pressure, and cholesterol levels);

23 “(7) evaluate and expand education and aware-
24 ness to physicians and other health care profes-

1 sionals regarding clinical practices for the prevention
2 of diabetes and the precursor conditions of diabetes;

3 “(8) review and recommend appropriate meth-
4 ods for outreach and dissemination of educational
5 resources that regard diabetes prevention and treat-
6 ments, are funded by the Federal Government, and
7 are intended for health care professionals and the
8 public; and

9 “(9) include other activities, such as those re-
10 lating to the areas of public health and nutrition,
11 that the Commission deems appropriate.

12 “(d) OPERATING PLAN.—

13 “(1) INITIAL PLAN.—Not later than 90 days
14 after its first meeting, the Commission shall submit
15 to the Secretary and the Congress an operating plan
16 for carrying out the activities of the Commission as
17 described in subsection (c). Such operating plan may
18 include—

19 “(A) a list of specific activities that the
20 Commission plans to conduct for purposes of
21 carrying out the duties described in each of the
22 paragraphs in subsection (c);

23 “(B) a plan for completing the activities;

24 “(C) a list of members of the Commission
25 and other individuals who are not members of

1 the Commission who will need to be involved to
2 conduct such activities;

3 “(D) an explanation of Federal agency in-
4 volvement and coordination needed to conduct
5 such activities;

6 “(E) a budget for conducting such activi-
7 ties;

8 “(F) a plan for evaluating the value and
9 potential impact of the Commission’s work and
10 recommendations, including the possible con-
11 tinuation of the Commission for the purposes of
12 overseeing their implementation; and

13 “(G) other information that the Commis-
14 sion deems appropriate.

15 “(2) UPDATES.—The Commission shall periodi-
16 cally update the operating plan under paragraph (1)
17 and submit such updates to the Secretary and the
18 Congress.

19 “(e) FINAL REPORT AND SUNSET OF THE COMMIS-
20 SION.—By not later than 3 years after the date of the
21 Commission’s first meeting, the Commission shall submit
22 to the Secretary and the Congress a report containing all
23 of the findings and recommendations of the Commission.
24 Not later than 120 days after the submission of the final
25 report, the Secretary shall review the evaluation required

1 under subsection (d)(1)(F) to determine the continuation
2 of the Commission.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—Appro-
4 priations are authorized to be made available to the Com-
5 mission for each of fiscal years 2013, 2014, and 2015,
6 from amounts otherwise made available to the Department
7 of Health and Human Services for such fiscal years, to
8 carry out this section.”.

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