

113TH CONGRESS
1ST SESSION

H. R. 2477

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 25, 2013

Mrs. CAPPS (for herself and Mr. BOUSTANY) 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 for coverage of cancer care planning and coordination under the Medicare program.

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 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Planning Actively for Cancer Treatment (PACT) Act of
6 2013”.

7 (b) **FINDINGS.**—Congress makes the following find-
8 ings:

1 (1) Individuals with cancer often do not have
2 access to a cancer care system that incorporates
3 shared decision-making and the coordination of all
4 elements of care.

5 (2) The cancer care system has not traditionally
6 offered individuals with cancer a shared decision-
7 making process, a prospective and comprehensive
8 plan for treatment, symptom management and sup-
9 portive care, strategies for updating and evaluating
10 such plan with the assistance of a health care pro-
11 fessional, and a follow-up plan for monitoring and
12 treating possible late effects of cancer and its treat-
13 ment.

14 (3) Cancer survivors often experience the
15 under-diagnosis and under-treatment of the symp-
16 toms of cancer, a problem that begins at the time
17 of diagnosis and may become more severe with dis-
18 ease progression and at the end of life. The failure
19 to treat the symptoms, side effects, and late effects
20 of cancer and cancer treatment may have a serious
21 adverse impact on the health, survival, well-being,
22 and quality of life of cancer survivors.

23 (4) The 1999 Institute of Medicine report enti-
24 tled “The Unequal Burden of Cancer” found that
25 low-income people often lack access to adequate can-

1 cer care and that ethnic minorities have not bene-
2 fitted fully from cancer treatment advances.

3 (5) Individuals with cancer often do not partici-
4 pate in a shared decision-making process that con-
5 siders all treatment options and do not benefit from
6 coordination of all elements of active treatment and
7 palliative care.

8 (6) Quality cancer care should incorporate ac-
9 cess to psychosocial services and management of the
10 symptoms of cancer and the symptoms of cancer
11 treatment, including pain, nausea, vomiting, fatigue,
12 and depression.

13 (7) Quality cancer care should include a means
14 for engaging cancer survivors in a shared decision-
15 making process that produces a comprehensive care
16 summary and a plan for follow-up care after primary
17 treatment to ensure that cancer survivors have ac-
18 cess to follow-up monitoring and treatment of pos-
19 sible late effects of cancer and cancer treatment, in-
20 cluding appropriate psychosocial services.

21 (8) The Institute of Medicine report entitled
22 “Ensuring Quality Cancer Care” described the ele-
23 ments of quality care for an individual with cancer
24 to include—

1 (A) the development of initial treatment
2 recommendations by an experienced health care
3 provider;

4 (B) the development of a plan for the
5 course of treatment of the individual and com-
6 munication of the plan to the individual;

7 (C) access to the resources necessary to
8 implement the course of treatment;

9 (D) access to high-quality clinical trials;

10 (E) a mechanism to coordinate services for
11 the treatment of the individual; and

12 (F) psychosocial support services and com-
13 passionate care for the individual.

14 (9) In its report “From Cancer Patient to Can-
15 cer Survivor: Lost in Transition”, the Institute of
16 Medicine recommended that individuals with cancer
17 completing primary treatment be provided a com-
18 prehensive summary of their care along with a fol-
19 low-up survivorship plan of treatment.

20 (10) In “Cancer Care for the Whole Patient”,
21 the Institute of Medicine stated that the develop-
22 ment of a plan that includes biomedical and psycho-
23 social care should be a standard for quality cancer
24 care in any quality measurement system.

1 (11) Because more than half of all cancer diag-
2 noses occur among elderly Medicare beneficiaries,
3 cancer care inadequacies should be addressed
4 through the Medicare program.

5 (12) Shortcomings in providing cancer care, re-
6 sulting in a lack of shared decision-making, inad-
7 equate management of cancer symptoms, and insuf-
8 ficient monitoring and treatment of late effects of
9 cancer and its treatment, relate in part to the inad-
10 equacy of Medicare payments for such planning and
11 coordination services.

12 (13) Changes in Medicare payment for cancer
13 care planning and coordination will support shared
14 decision-making that reviews all treatment options
15 and will contribute to improved care for individuals
16 with cancer from the time of diagnosis through the
17 end of the life.

18 **SEC. 2. COVERAGE OF CANCER CARE PLANNING AND CO-**
19 **ORDINATION SERVICES.**

20 (a) IN GENERAL.—Section 1861 of the Social Secu-
21 rity Act (42 U.S.C. 1395x) is amended—

22 (1) in subsection (s)(2)—

23 (A) by striking “and” at the end of sub-
24 paragraph (EE);

1 (B) by adding “and” at the end of sub-
2 paragraph (FF); and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(GG) cancer care planning and coordination
6 services (as defined in subsection (iii))”; and

7 (2) by adding at the end the following new sub-
8 section:

9 “Cancer Care Planning and Coordination Services

10 “(iii)(1) The term ‘cancer care planning and coordi-
11 nation services’ means—

12 “(A) with respect to an individual who is diag-
13 nosed with cancer, the development of a treatment
14 plan by a physician, nurse practitioner, or physician
15 assistant that—

16 “(i) includes an assessment of the individ-
17 ual’s diagnosis, health status, treatment needs,
18 functional status, pain control, and psychosocial
19 needs;

20 “(ii) engages the individual in a shared de-
21 cision-making process that reviews all treatment
22 options;

23 “(iii) details, to the greatest extent prac-
24 ticable all aspects of the care to be provided to
25 the individual with respect to the treatment of

1 such cancer, including any curative treatment,
2 comprehensive symptom management, and pal-
3 liative care;

4 “(iv) is furnished in person, in written
5 form, to the individual within a period specified
6 by the Secretary that is as soon as practicable
7 after the date on which the individual is so di-
8 agnosed;

9 “(v) is furnished, to the greatest extent
10 practicable, in a form that appropriately takes
11 into account cultural and linguistic needs of the
12 individual in order to make the plan accessible
13 to the individual; and

14 “(vi) is in accordance with standards de-
15 termined by the Secretary to be appropriate;

16 “(B) with respect to an individual for whom a
17 treatment plan has been developed under subpara-
18 graph (A), the revision of such treatment plan as
19 necessary to account for any substantial change in
20 the condition of the individual, recurrence of disease,
21 changes in the individual’s treatment preferences, or
22 significant revision of the elements of curative care
23 or symptom management for the individual, if such
24 revision—

1 “(i) is in accordance with clauses (i), (ii),
2 (iv) and (v) of such subparagraph; and

3 “(ii) is furnished in written form to the in-
4 dividual within a period specified by the Sec-
5 retary that is as soon as practicable after the
6 date of such revision;

7 “(C) with respect to an individual who has com-
8 pleted the primary treatment for cancer, as defined
9 by the Secretary, the development of a follow-up sur-
10 vivorship care plan that—

11 “(i) includes an assessment of the individ-
12 ual’s diagnosis, health status, treatment needs,
13 functional status, pain control, and psychosocial
14 needs;

15 “(ii) engages the individual in a shared de-
16 cision-making process that reviews all survivor-
17 ship care options;

18 “(iii) describes the elements of the primary
19 treatment, including symptom management and
20 palliative care, furnished to such individual;

21 “(iv) provides recommendations for the
22 subsequent care of the individual with respect
23 to the cancer involved;

24 “(v) is furnished, in person, in written
25 form, to the individual within a period specified

1 by the Secretary that is as soon as practicable
2 after the completion of such primary treatment;

3 “(vi) is furnished, to the greatest extent
4 practicable, in a form that appropriately takes
5 into account cultural and linguistic needs of the
6 individual in order to make the plan accessible
7 to the individual; and

8 “(vii) is in accordance with standards de-
9 termined by the Secretary to be appropriate;
10 and

11 “(D) with respect to an individual for whom a
12 follow-up cancer care plan has been developed under
13 subparagraph (C), the revision of such plan as nec-
14 essary to account for any substantial change in the
15 condition of the individual, diagnosis of a second
16 cancer, change in the individual’s preference for sur-
17 vivorship care, or significant revision of the plan for
18 follow-up care, if such revision—

19 “(i) is in accordance with clauses (i), (ii),
20 (iii), (v), and (vi) of such subparagraph; and

21 “(ii) is furnished in written form to the in-
22 dividual within a period specified by the Sec-
23 retary that is as soon as practicable after the
24 date of such revision.

1 “(2) The Secretary shall establish standards to carry
2 out paragraph (1) in consultation with appropriate organi-
3 zations representing suppliers and providers of services re-
4 lated to cancer treatment and organizations representing
5 survivors of cancer. Such standards shall include stand-
6 ards for determining the need and frequency for revisions
7 of the treatment plans and follow-up survivorship care
8 plans based on changes in the condition of the individual
9 or elements and intent of treatment and standards for the
10 communication of the plan to the individual.

11 “(3) In this subsection, the term ‘shared decision-
12 making process’ means, with respect to an individual, a
13 process in which the individual and the individual’s health
14 care providers consider the individual’s diagnosis, treat-
15 ment options, the medical evidence related to treatment
16 options, the risks and benefits of all treatment options,
17 and the individual’s preferences regarding treatment, and
18 then jointly develop and implement a treatment plan.”.

19 (b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

20 (1) IN GENERAL.—Section 1848(j)(3) of the
21 Social Security Act (42 U.S.C. 1395w-4(j)(3)) is
22 amended by inserting “(GG),” after “health risk as-
23 sessment),”.

24 (2) INITIAL RATES.—Unless the Secretary of
25 Health and Human Services otherwise provides, the

1 payment rate specified under the physician fee
2 schedule under the amendment made by paragraph
3 (1) for cancer care planning and coordination serv-
4 ices shall be the same payment rate as provided for
5 transitional care management services (as defined in
6 CPT code 99496).

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to services furnished on or after
9 the first day of the first calendar year that begins after
10 the date of the enactment of this Act.

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