

106TH CONGRESS
2^D SESSION

H. R. 4981

To amend title XVIII of the Social Security Act to establish a national policy on chronic illness care, to improve administrative, delivery, and financing capabilities, to establish prototype models for serving persons with serious and disabling chronic conditions, to provide for coverage under the Medicare Program of disease management services for serious and disabling chronic illnesses, and to refine Medicare and Medicaid waiver authority.

IN THE HOUSE OF REPRESENTATIVES

JULY 26, 2000

Mr. STARK introduced the following bill; which was referred to the Committee on 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 establish a national policy on chronic illness care, to improve administrative, delivery, and financing capabilities, to establish prototype models for serving persons with serious and disabling chronic conditions, to provide for coverage under the Medicare Program of disease management services for serious and disabling chronic illnesses, and to refine Medicare and Medicaid waiver authority.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Chronic Illness Care Improvement Act of 2000”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

**TITLE I—NATIONAL COMMISSION ON IMPROVING CHRONIC
ILLNESS CARE**

Sec. 101. National Commission on Improving Chronic Illness Care.

Sec. 102. Definition of serious and disabling chronic illness.

**TITLE II—PREPARING THE GROUNDWORK FOR THE NATIONAL
INITIATIVE TO IMPROVE CHRONIC ILLNESS CARE**

Subtitle A—Expansion of Preventive Benefits

Sec. 201. Authority to provide preventive services under part B of the medicare program to prevent, reduce, delay, or detect serious and disabling chronic illness.

Sec. 202. Information campaign on prevention.

Sec. 203. Study of ways to encourage lifetime preventive care designed to minimize chronic illness costs in the public and private sectors.

Sec. 204. Congressional consideration of cost effectiveness of chronic illness prevention measures over time.

**Subtitle B—Development of National Goals and Measures for the Effective
Management of Chronic Illness**

Sec. 211. Establishment of a new office in the Department of Health and Human Services to ensure coordination of care for chronic illness.

Sec. 212. Establishment of a national database for chronic illness.

Sec. 213. Establishment of national goals to reduce the prevalence of high-cost chronic illness.

Sec. 214. Establishment of quality improvement, medical error reduction and outcomes goals.

Sec. 215. Development and implementation of common patient assessment instruments across settings.

Sec. 216. Development of national resource centers on the internet for serious and disabling chronic illness.

**Subtitle C—Payment Incentives for Furnishing Quality Services to the
Chronically Ill**

Sec. 221. Bonus payments to Medicare+Choice organizations implementing comprehensive programs of disease and disability prevention that achieve prevention goals established by the Secretary.

Sec. 222. Increased attention to payment policies for the chronically ill under Medicare+Choice.

Sec. 223. Assuring adequate manpower and expertise for the treatment of chronic illness.

TITLE III—DEVELOPMENT OF PROTOTYPES OF INTEGRATION AND COORDINATION OF CARE FOR 2 CHRONIC ILLNESS SUBPOPULATIONS TO BE EXPANDED IN 2007 TO ALL SERIOUS AND DISABLING CHRONIC ILLNESSES

Sec. 301. Disease management services for serious and disabling chronic illness.
“Sec. 1889. Disease management services for serious and disabling chronic illness.

TITLE IV—INTEGRATING MEDICARE AND MEDICAID FOR DUAL ELIGIBLES

Sec. 401. Provision of waiver authority to serve dual eligibles more efficiently.
“Sec. 1897. Demonstrations to coordinate and integrate services and administration under this title and title XIX.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Chronic disease is America’s number one
4 health care problem, yet chronic care is provided by
5 a fragmented health care system that was designed
6 to meet the needs of acute episodes of illness.

7 (2) Chronic disease is America’s highest cost
8 and fastest growing health care problem, accounting
9 for 90 percent of all morbidity and 80 percent of all
10 deaths. While chronic conditions affect persons of all
11 ages, the elderly are at the greatest risk. About 88
12 percent of the elderly have 1 chronic condition and
13 almost 70 percent have more than 1 condition. The
14 number of persons over 65 years of age will increase
15 from 13 percent of the population to almost 21 per-
16 cent in 2040.

1 (3) Direct and indirect costs for chronic condi-
2 tions reached \$659,000,000,000 in 1990 and are
3 projected to nearly double by the year 2050. Per
4 capita medical expenditures for persons with chronic
5 conditions are, on average, almost 4 times the costs
6 for persons with acute conditions. Nearly 70 percent
7 of the Nation's personal health care expenditures are
8 for people with chronic conditions.

9 (4) The needs of the chronically ill span time,
10 place, and health profession, yet providers and infor-
11 mation systems function to deliver separate and un-
12 related services, even though they are providing care
13 to the same person. The current structure of admin-
14 istration, financing, and oversight of Government-
15 sponsored programs locks into place a fragmented,
16 institutionally based, reactive approach to care that
17 is at odds with the coordinated and seamless con-
18 tinuum of care chronic illness requires.

19 (5) This systems problem requires a systems so-
20 lution based on the following components:

21 (A) Extended care pathways that follow
22 patients across settings and include preventive,
23 primary, acute, transitional, and residential and
24 community-based long-term care services.

1 (B) Targeted approaches to care delivery
2 for high-risk populations including screening
3 programs, early intervention, and clinical guide-
4 lines for preventing, delaying, or minimizing
5 disability.

6 (C) Health promotion strategies, including
7 patient education, that encourage self-manage-
8 ment and patient empowerment.

9 (D) Chronic disease management and case
10 management with the authority to manage care,
11 utilization, and costs across the spectrum of
12 services.

13 (E) Integrated information systems that
14 track health status, utilization, cost, and quality
15 data across providers/settings and throughout
16 the course of chronic conditions.

17 (F) Financing strategies that align finan-
18 cial incentives among providers to achieve mu-
19 tual and consistent care, quality, and cost ob-
20 jectives.

21 (G) Education for health professionals to
22 meet the long-term comprehensive needs of
23 chronic conditions.

24 (H) Support for family caregivers through
25 the development of integrated models of family

1 centered care that encompass health and sup-
2 portive services for patients and family care-
3 givers.

4 (6) This transformation of health care delivery
5 for chronic conditions will result in a dramatic im-
6 provement in the quality of care characterized by—

7 (A) a reduction in the prevalence of chron-
8 ic conditions;

9 (B) a reduction in the progression of dis-
10 ability;

11 (C) improved functional status at all
12 stages of chronic disease;

13 (D) improved patient satisfaction; and

14 (E) improved quality of life.

15 (7) The cost of this new approach to chronic
16 care will be borne by a combination of short-term
17 and long-term savings as follows:

18 (A) Short-term savings result from a re-
19 duction of duplicative services (including mul-
20 tiple admissions and discharges with mandated
21 comprehensive intake assessments and dis-
22 charge plans) from today’s “silos” of health
23 care settings, as well as unnecessary diagnostic
24 investigations and consultations that result
25 from inaccessible data.

1 (B) Long-term savings result from the re-
2 duction in preventable complications and the
3 prolongation of functional independence. Soci-
4 etal costs related to lost productivity and work-
5 days for both patients and caregivers will also
6 decline.

7 **TITLE I—NATIONAL COMMIS-**
8 **SION ON IMPROVING CHRON-**
9 **IC ILLNESS CARE**

10 **SEC. 101. NATIONAL COMMISSION ON IMPROVING CHRONIC**
11 **ILLNESS CARE.**

12 (a) ESTABLISHMENT.—There is established a com-
13 mission to be known as the National Commission on Im-
14 proving Chronic Illness Care (in this section referred to
15 as the “Commission”).

16 (b) DUTIES OF THE COMMISSION.—The Commission
17 shall carry out the following duties:

18 (1) Develop a national policy to coordinate the
19 multiple Federal resources devoted to health care for
20 persons with serious and disabling chronic illnesses
21 in order to facilitate a comprehensive continuum of
22 care. With respect to chronically ill persons who are
23 eligible for health care benefits under any or any
24 combination of the medicare or medicaid programs
25 (administered by the Department of Health and

1 Human Services), or under chapter 17 of title 38,
2 United States Code (administered by the Depart-
3 ment of Veterans Affairs), the Commission shall give
4 special emphasis to coordination of health care and
5 related services furnished by those departments and
6 other departments serving medicare beneficiaries, in-
7 cluding the Departments of Agriculture, Interior,
8 and Housing and Urban Development. The Commis-
9 sion shall examine how these programs can be made
10 to coordinate better with each other and with State
11 and local programs to provide a continuum of care
12 to those with serious and disabling chronic illnesses.

13 (2) Review and analyze whether coordination of
14 the multiple Federal resources is best accomplished
15 by a completely new governmental structure, or a
16 new structure within an existing department, or a
17 new mechanism for coordination of the various Gov-
18 ernment programs.

19 (3) Make suggestions regarding amendments to
20 the provisions of titles II, III, and IV of this Act.

21 (4) Identify statutory and regulatory barriers to
22 effective care for serious and disabling chronic ill-
23 ness and develop recommendations for legislative
24 and regulatory changes that would facilitate the
25 goals in the provisions described in paragraph (4),

1 including barriers to the coordination of care across
2 provider settings and the coordination of benefit cov-
3 erage under Federal and State programs, with spe-
4 cial attention given to the medicare and medicaid
5 programs.

6 (5) Develop a plan to integrate medicare and
7 medicaid Federal budget functions for purposes of
8 projecting future costs of serious and disabling
9 chronic conditions and cost savings from improved
10 care of the chronically ill. These costs and cost sav-
11 ings must be measured longitudinally and across
12 professional disciplines and provider settings.

13 (6) Develop guidelines for payment methods
14 that establish compatible financial incentives among
15 health care providers and professionals serving the
16 same chronically ill persons in order to facilitate in-
17 creased quality of care, greater cost effectiveness,
18 and simplicity of billing for providers and bene-
19 ficiaries.

20 (7) Commission an expert panel, including ex-
21 perts in disease management, care of serious and
22 disabling chronic illness, and outcomes research, to
23 make recommendations for the design of the proto-
24 types, supervise data gathering, generate feedback,
25 and define endpoints in order to analyze the experi-

1 ence of the prototypes, (the National Diabetes Pilot
2 Initiative to Improve Chronic Illness Care and the
3 National Alzheimer’s Disease Pilot Initiative To Im-
4 prove Chronic Illness Care established under title
5 III) in order to enhance the design of the later ex-
6 panded program (The National Initiative to Improve
7 Chronic Illness Care). The expert panel will meet
8 concurrently during the tenure of the Commission
9 and will reconvene in the third year of the National
10 Diabetes and Alzheimer’s Disease Pilot Initiatives to
11 review the operation and outcomes of those initia-
12 tives and submit a report of their recommendations
13 not later than 12 months after they reconvene. Such
14 expert panel may hold hearings and otherwise seek
15 advice from the public and outside experts, develop
16 papers, and seek a consensus on its recommenda-
17 tions.

18 (8) Commission an expert panel to develop a
19 plan to introduce a single, integrated medical record
20 for patients with chronic conditions in order to elimi-
21 nate duplication of assessment, care planning, and
22 documentation functions and to allow physician or-
23 ders, chart information, diagnoses, and assessments
24 to flow continuously across levels of care. Such ex-
25 pert panel may hold hearings and otherwise seek ad-

1 vice from the public and outside experts, develop pa-
2 pers, and seek a consensus on its recommendations.

3 (9) Commission an expert panel to recommend
4 new outcome measures of cost-effectiveness based on
5 improvements in or maintenance of functional sta-
6 tus, delayed dependency, reducing the rate of dis-
7 ability progression, quality of life, and such other re-
8 lated matters as the panel determines appropriate.
9 Such expert panel may hold hearings and otherwise
10 seek advice from the public and outside experts, de-
11 velop papers, and seek a consensus on its rec-
12 ommendations.

13 (10) Contract for reports detailing the need for
14 changes in current laws and regulations in order to
15 achieve the aforementioned provisions.

16 (11) Recommend national goals for reduction in
17 serious and disabling chronic illness and cost savings
18 over the next generation.

19 (12) Analyze the impact of emerging trends in
20 the management of serious and disabling chronic ill-
21 ness, disability, and long-term care, including such
22 issues as genetic testing, Internet technology, patient
23 empowerment, and increasing utilization of home
24 health care and their implications for future health
25 care delivery to the chronically ill.

1 (13) Review and analyze such other matters as
2 the Commission determines to be appropriate.

3 (c) MEMBERSHIP.—

4 (1) NUMBER AND APPOINTMENT.—

5 (A) IN GENERAL.—Subject to subpara-
6 graph (B), the Commission shall be composed
7 of 17 members of whom—

8 (i) 4 shall be appointed by the Presi-
9 dent;

10 (ii) 6 shall be appointed by the Speak-
11 er of the House of Representatives, in con-
12 sultation with the minority leader of the
13 House of Representatives, of whom not
14 more than 4 shall be of the same political
15 party;

16 (iii) 6 shall be appointed by the ma-
17 jority leader of the Senate, in consultation
18 with the minority leader of the Senate, of
19 whom not more than 4 shall be of the
20 same political party; and

21 (iv) 1, who shall serve as Chairman of
22 the Commission, appointed jointly by the
23 Speaker of the House of Representatives,
24 in consultation with the minority leader of
25 the House of Representatives.

1 (B) LIMITATION ON NUMBER OF MEMBERS
2 OF CONGRESS.—Of the members appointed
3 under subparagraph (A), no more than 2 mem-
4 bers of the House of Representatives and 2
5 members of the Senate may serve as a member
6 of the Commission.

7 (C) QUALIFICATIONS.—Members of the
8 Commission shall include representatives
9 from—

- 10 (i) Federal and State agencies serving
11 the elderly, disabled, and chronically ill;
12 (ii) public health;
13 (iii) consumer representatives for var-
14 ious chronic diseases;
15 (iv) primary care providers;
16 (v) acute care providers;
17 (vi) institutional and community-
18 based long-term care providers;
19 (vii) managed care health plans; and
20 (viii) researchers in health care fi-
21 nancing and chronic disease management.

22 (2) DEADLINE FOR APPOINTMENT.—Members
23 of the Commission shall be appointed by not later
24 than 90 days after the enactment of this Act.

1 (3) TERMS OF APPOINTMENT.—The term of
2 any appointment under paragraph (1) to the Com-
3 mission shall be for the life of the Commission.

4 (4) MEETINGS.—The Commission shall meet at
5 the call of its Chairman or a majority of its mem-
6 bers.

7 (5) QUORUM.—A quorum shall consist of 8
8 members of the Commission, except that 4 members
9 may conduct a hearing under subsection (e).

10 (6) VACANCIES.—A vacancy on the Commission
11 shall be filled in the same manner in which the origi-
12 nal appointment was made, not later than 30 days
13 after the Commission is given notice of the vacancy
14 and shall not affect the power of the remaining
15 members to execute the duties of the Commission.

16 (7) COMPENSATION.—Members of the Commis-
17 sion shall receive no additional pay, allowances, or
18 benefits by reason of their service on the Commis-
19 sion.

20 (8) EXPENSES.—Each member of the Commis-
21 sion shall receive travel expenses and per diem in
22 lieu of subsistence in accordance with sections 5702
23 and 5703 of title 5, United States Code.

24 (d) STAFF AND SUPPORT SERVICES.—

25 (1) EXECUTIVE DIRECTOR.—

1 (A) APPOINTMENT.—The Chairman shall
2 appoint an executive director of the Commis-
3 sion.

4 (B) COMPENSATION.—The executive direc-
5 tor shall be paid the rate of basic pay for level
6 V of the Executive Schedule.

7 (2) STAFF.—With the approval of the Commis-
8 sion, the executive director may appoint such per-
9 sonnel as the executive director considers appro-
10 priate.

11 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—
12 The staff of the Commission shall be appointed with-
13 out regard to the provisions of title 5, United States
14 Code, governing appointments in the competitive
15 service, and shall be paid without regard to the pro-
16 visions of title 5, United States Code, governing ap-
17 pointments in the competitive service, and shall be
18 paid without regard to the provisions of chapter 51
19 and subchapter III of chapter 53 of such title (relat-
20 ing to classification and General Schedule pay
21 rates).

22 (4) EXPERTS AND CONSULTANTS.—With the
23 approval of the Commission, the executive director
24 may procure temporary and intermittent services
25 under section 3109(b) of title 5, United States Code.

1 (5) PHYSICAL FACILITIES.—The Administrator
2 of the General Services Administration shall locate
3 suitable office space for the operation of the Com-
4 mission. The facilities shall serve as the head-
5 quarters of the Commission and shall include all
6 necessary equipment and incidentals required for the
7 proper functioning of the Commission.

8 (e) POWERS OF COMMISSION.—

9 (1) HEARINGS AND OTHER ACTIVITIES.—For
10 the purpose of carrying out its duties, the Commis-
11 sion may hold such hearings and undertake such
12 other activities as the Commission determines to be
13 necessary to carry out its duties.

14 (2) STUDIES BY GAO.—Upon the request of the
15 Commission, the Comptroller General shall conduct
16 such studies or investigations as the Commission de-
17 termines to be necessary to carry out its duties.

18 (3) COST ESTIMATES BY CONGRESSIONAL
19 BUDGET OFFICE AND OFFICE OF THE CHIEF ACTU-
20 ARY OF HCFA.—

21 (A) The Director of the Congressional
22 Budget Office or the Chief Actuary of the
23 Health Care Financing Administration, or both,
24 shall provide to the Commission, upon the re-
25 quest of the Commission, such cost estimates as

1 the Commission determines to be necessary to
2 carry out its duties.

3 (B) The Commission shall reimburse the
4 Director of the Congressional Budget Office for
5 expenses relating to the employment in the of-
6 fice of the Director of such additional staff as
7 may be necessary for the Director to comply
8 with requests by the Commission under sub-
9 paragraph (A).

10 (4) **DETAIL OF FEDERAL EMPLOYEES.**—Upon
11 the request of the Commission, the head of a Fed-
12 eral agency shall provide such technical assistance to
13 the Commission as the Commission determines to be
14 necessary to carry out its duties. Any such detail
15 shall not interrupt or otherwise affect the civil serv-
16 ice status or privileges of the Federal employee.

17 (5) **TECHNICAL ASSISTANCE.**—Upon the re-
18 quest of the Commission, the head of a Federal
19 agency shall provide such technical assistance to the
20 Commission as the Commission determines to be
21 necessary to carry out its duties.

22 (6) **USE OF MAILS.**—The Commission may use
23 the United States mails in the same manner and
24 under the same conditions as Federal agencies and
25 shall, for purposes of the frank, be considered a

1 commission of Congress as described in section 3215
2 of title 39, United States Code.

3 (7) OBTAINING INFORMATION.—The Commis-
4 sion may secure directly from any Federal agency
5 information necessary to enable it to carry out its
6 duties, if the information may be disclosed under
7 section 552 of title 5, United States Code. Upon re-
8 quest of the Chairman of the Commission, the head
9 of such agency shall furnish such information to the
10 Commission.

11 (8) ADMINISTRATIVE SUPPORT SERVICES.—
12 Upon the request of the Commission, the Adminis-
13 trator of General Services shall provide to the Com-
14 mission on a reimbursable basis such administrative
15 support services as the Commission may request.

16 (9) PRINTING.—For purposes of costs relating
17 to printing and binding, including the cost of per-
18 sonnel detailed from the Government Printing Of-
19 fice, the Commission shall be deemed to be a com-
20 mittee of the Congress.

21 (f) REPORT.—Not later than 18 months following the
22 first meeting of the Commission, the Commission shall
23 submit a report to the President and Congress which shall
24 contain a detailed statement of only those recommenda-
25 tions, findings, and conclusions of the Commission that

1 receive the approval of at least 11 members of the Com-
2 mission.

3 (g) TERMINATION.—The Commission shall terminate
4 30 days after the date of submission of the report required
5 in subsection (f).

6 (h) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated \$1,500,000 to carry out
8 this section. 60 percent of such appropriation shall be pay-
9 able from the Federal hospital insurance trust fund, and
10 40 percent of such appropriation shall be payable from
11 the Federal Supplementary Medical Insurance Trust
12 Fund under title XVIII of the Social Security Act (42
13 U.S.C. 1395I, 1395t).

14 **SEC. 102. DEFINITION OF SERIOUS AND DISABLING CHRON-**
15 **IC ILLNESS.**

16 In this Act, the term “serious and disabling chronic
17 illness’ means one or more biological or physical conditions
18 which are likely to last for an unspecified period of time,
19 or for the duration of a person’s life, for which there is
20 no known cure, and which may affect an individual’s abil-
21 ity to carry out basic activities of daily living, instrumental
22 activities of daily living, or both. Such conditions include
23 the following:

24 (1) Alzheimer’s Disease and related disorders.

25 (2) Arthritis.

- 1 (3) Cancer.
- 2 (4) Cerebrovascular disease.
- 3 (5) Diabetes.
- 4 (6) Emphysema and bronchitis (including
- 5 chronic obstructive pulmonary disease.
- 6 (7) Hypertension.
- 7 (8) Ischemic heart disease.
- 8 (9) Multiple sclerosis.
- 9 (10) Parkinson’s disease.
- 10 (11) Peripheral vascular disease.
- 11 (12) Renal disease.

12 **TITLE II—PREPARING THE**
13 **GROUNDWORK FOR THE NA-**
14 **TIONAL INITIATIVE TO IM-**
15 **PROVE CHRONIC ILLNESS**
16 **CARE**

17 **Subtitle A—Expansion of**
18 **Preventive Benefits**

19 **SEC. 201. AUTHORITY TO PROVIDE PREVENTIVE SERVICES**
20 **UNDER PART B OF THE MEDICARE PROGRAM**
21 **TO PREVENT, REDUCE, DELAY, OR DETECT**
22 **SERIOUS AND DISABLING CHRONIC ILLNESS.**

23 (a) PREVENTIVE SERVICES BENEFIT.—

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

1 (A) by redesignating paragraphs (16) and
2 (17) as paragraphs (17) and (18), respectively;

3 (B) by striking “and” at the end of para-
4 graph (14);

5 (C) by striking the period at the end of
6 paragraph (15) and inserting “and”; and

7 (D) by inserting after paragraph (15) the
8 following new paragraph:

9 “(16) qualified preventive services, as defined in
10 subsection (uu);”.

11 (2) CONFORMING AMENDMENTS.—Sections
12 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of
13 such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and
14 1396n(a)(1)(B)(ii)(I)) are each amended by striking
15 “paragraphs (16) and (17)” each place it appears
16 and inserting “paragraphs (17) and (18)”.

17 (b) DEFINITION OF PREVENTIVE SERVICES.—Sec-
18 tion 1861 of such Act (42 U.S.C. 1395x) is amended by
19 adding at the end the following new subsection:

20 “Qualified Preventive Services

21 “(uu)(1) Subject to paragraph (2), the term ‘quali-
22 fied preventive services’ means items and services deter-
23 mined by the Secretary, on the basis of evidence, to be
24 reasonable and necessary for the prevention, reduction,
25 delay, or early detection of a chronic illness, that are fur-

1 nished by qualified health care professionals (as deter-
 2 mined by the Secretary) in such amounts and with such
 3 frequency as the Secretary determines appropriate con-
 4 sistent with the provisions of paragraph (2), and includes
 5 the following services so furnished:

6 “(A) Smoking cessation services.

7 “(B) Screening for hypertension.

8 “(C) Screening for cholesterol.

9 “(D) Screening for end stage renal disease and
 10 kidney function.

11 “(E) Fall prevention services.

12 “(F) Counseling for hormone replacement ther-
 13 apy.

14 “(G) Screening for reduced visual and audio
 15 acuity and low vision rehabilitation services.

16 “(H) Screening for glaucoma.

17 “(I) Medical nutrition therapy services, includ-
 18 ing obesity and weight reduction and weight reduc-
 19 tion maintenance services.

20 (c) EXCLUSION FROM COVERAGE CONFORMING
 21 AMENDMENT.—Section 1862(a)(1)(B) of such Act (42
 22 U.S.C. 1395y(a)(1)(B)) is amended by striking “section
 23 1861(s)(10)” and inserting “section 1834(e)(6)”.

24 (d) PAYMENT FOR PREVENTIVE SERVICES.—

1 (1) IN GENERAL.—Section 1834 of the Social
2 Security Act (42 U.S.C. 1395m) is amended by in-
3 serting after subsection (d) the following new sub-
4 section:

5 “(e) ALTERNATIVE PAYMENT FOR PREVENTIVE
6 SERVICES.—

7 “(1) GENERAL PAYMENT RULE.—

8 “(A) QUALIFIED PREVENTIVE SERVICES.—

9 The Secretary shall establish by regulation a
10 payment amount for qualified preventive serv-
11 ices, as defined in section 1861(uu).

12 “(B) OTHER PREVENTIVE SERVICES.—The
13 Secretary may establish by regulation a pay-
14 ment amount for each type of preventive service
15 described in subparagraphs (A) through (H) of
16 paragraph (6).

17 “(2) MINIMUM PAYMENT AMOUNT.—In the case
18 of a preventive service described in paragraph (6)
19 that may be performed as a diagnostic or thera-
20 peutic service under this title, the payment amount
21 under this subsection for a service performed as a
22 preventive service may not be less than the payment
23 amount established under this title for such service
24 performed as a diagnostic or therapeutic service.

1 “(3) MANNER OF PAYMENT.—In the case of a
2 preventive service described in paragraph (6) that
3 may be performed as a diagnostic or therapeutic
4 service under this title, the Secretary shall apply the
5 same method of payment under this subsection for
6 a service performed as a preventive service as the
7 Secretary applies under this title for such service
8 performed as a diagnostic or therapeutic service.

9 “(4) AUTHORITY TO WAIVE COINSURANCE.—
10 Notwithstanding any other provision of this title, in
11 the case of a preventive service described in para-
12 graph (6), the Secretary may waive the imposition of
13 any applicable coinsurance amount with respect to
14 such service.

15 “(5) PROHIBITION ON BALANCE BILLING.—The
16 provisions of subparagraphs (A) and (B) of section
17 1842(b)(18) shall apply to the furnishing of preven-
18 tive services described in paragraph (6) for which
19 payment is made under this subsection in the same
20 manner as such subparagraphs apply to services fur-
21 nished by a practitioner described in subparagraph
22 (C) of such section.

23 “(6) PREVENTIVE SERVICES DESCRIBED.—For
24 purposes of this subsection, the preventive services

1 described in this paragraph are any of the following
2 services:

3 “(A) Antigens (under section
4 1861(s)(2)(G)).

5 “(B) Prostate cancer screening tests (as
6 defined in section 1861(oo)).

7 “(C) Colorectal cancer screening tests (as
8 defined in section 1861(pp)).

9 “(D) Blood-testing strips, lancets, and
10 blood glucose monitors for individuals with dia-
11 betes described in section 1861(n).

12 “(E) Diabetes outpatient self-management
13 training services (as defined in section
14 1861(qq)).

15 “(F)(i) Pneumococcal vaccine and its ad-
16 ministration and influenza vaccine and its ad-
17 ministration (under section 1861(s)(10)(A)).

18 “(ii) Hepatitis B vaccine and its adminis-
19 tration (under section 1861(s)(10)(B)).

20 “(G) Screening mammography (as defined
21 in section 1861(jj)).

22 “(H) Screening pap smear and screening
23 pelvic exam (as defined in paragraphs (1) and
24 (2), respectively, of section 1861(nn)).

1 “(I) Bone mass measurement (as defined
2 in section 1861(rr)).

3 “(J) Qualified preventive services (as de-
4 fined in section 1861(uu)).”.

5 (2) WAIVER OF DEDUCTIBLE.—The first sen-
6 tence of section 1833(b) of such Act (42 U.S.C.
7 1395l(b)) is amended by striking “, (5) such deduct-
8 ible” and all that follows through the period and in-
9 serting: “, and (5) such deductible shall not apply
10 with respect to preventive services (as described in
11 section 1834(e)(6)).”.

12 (3) CONFORMING AMENDMENTS.—(A) Section
13 1833(a)(1)(B) of such Act (42 U.S.C.
14 1395l(a)(1)(B)) is amended by inserting “subject to
15 section 1834(e),” before “the amounts paid shall be
16 100 percent of the reasonable charges for such items
17 and services,”.

18 (B) Section 1833(a)(2)(G) of such Act (42
19 U.S.C. 1395l(a)(2)(G)) is amended by inserting
20 “subject to section 1834(e),” before “with respect to
21 items and services”.

22 (C) Section 1834(c)(1)(C) of such Act (42
23 U.S.C. 1395m(e)) is amended by striking “the
24 amount of the payment” and inserting “except as

1 provided by the Secretary under subsection (e), the
2 amount of the payment”

3 (D) Section 1834(d) of such Act (42 U.S.C.
4 1395m(d)) is amended—

5 (i) in paragraph (1)(A), by striking “The
6 payment amount” and inserting “Except as
7 provided by the Secretary under subsection (e),
8 the payment amount”; and

9 (ii) in paragraphs (2)(A) and (3)(A), by
10 striking “payment under section 1848” each
11 place it appears and inserting “except as pro-
12 vided by the Secretary under subsection (e),
13 payment under section 1848”.

14 (E) Section 1848(g)(2)(C) of such Act (42
15 U.S.C. 1395w-4(g)(2)(C)) is amended—

16 (i) by striking “For” and inserting “(i)
17 Subject to clause (ii), for”; and

18 (ii) by adding at the end the following new
19 clause:

20 “(ii) For physicians’ services consisting of
21 preventive services (as described in section
22 1834(e)(6)) furnished on or after February 1,
23 2000, the ‘limiting charge’ shall be 100 percent
24 of the recognized payment amount under this

1 part for nonparticipating physicians or for non-
2 participating suppliers or other persons.”.

3 (F) Section 1848(g)(2)(D) of such Act (42
4 U.S.C. 1395w-4(g)(2)(D)) is amended by striking
5 “the fee schedule amount determined under sub-
6 section (a)” and all that follows and inserting “the
7 fee schedule amount determined under subsection
8 (a), in the case of preventive services (as described
9 in section 1834(e)(6)) the amount determined by the
10 Secretary under section 1834(e), or, if payment
11 under this part is made on a basis other than the
12 fee schedule under this section or other than the
13 amount established under section 1834(e) with re-
14 spect to such preventive services, 95 percent of the
15 other payment basis.”.

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

21 (f) EFFECTIVE DATE.—The amendments made by
22 this Act apply to items and services furnished on or after
23 January 1, 2002.

1 **SEC. 202. INFORMATION CAMPAIGN ON PREVENTION.**

2 The Secretary of Health and Human Services shall
3 carry out, during 2002 and 2003, a nationwide education
4 campaign to promote awareness among all Americans
5 about the nature of chronic diseases and disabilities and
6 strategies for preventing, delaying, or minimizing dis-
7 ability progression at various stages of chronic conditions,
8 including health promotion and self-care activities. This
9 campaign shall include the following activities:

10 (1) An information campaign, in collaboration
11 with the Social Security Administration, State health
12 insurance assistance programs, area agencies on
13 aging, and the private sector, designed to educate all
14 Americans (especially individuals with disabilities)
15 about the importance of preventive health care.

16 (2) Activities designed to encourage medicare
17 beneficiaries to use medicare preventive benefits, in-
18 cluding distribution of comprehensive information on
19 medicare preventive benefits to all medicare bene-
20 ficiaries.

21 (3) Development and testing of a health status
22 assessment tool with follow-up interventions, to as-
23 sist medicare beneficiaries and their providers in
24 identifying and mitigating health risks.

25 (4) A nationwide education and awareness cam-
26 paign designed to educate older Americans on ad-

1 justments to behavior and the home environment
2 that can prevent falls and other injuries.

3 **SEC. 203. STUDY OF WAYS TO ENCOURAGE LIFETIME PRE-**
4 **VENTIVE CARE DESIGNED TO MINIMIZE**
5 **CHRONIC ILLNESS COSTS IN THE PUBLIC**
6 **AND PRIVATE SECTORS.**

7 (a) STUDY.—The Secretary of Health and Human
8 Services shall conduct a study to estimate what preventive
9 care services (such as smoking cessation and hypertension
10 reduction.) if furnished to individuals before eligibility for
11 medicare (either due to qualification by age or by social
12 security disability) could reasonably be expected to save
13 the medicare program and other Government programs
14 (including the tax revenues to the Treasury from contin-
15 ued employment by individuals free of morbidity) more in
16 future discounted costs under those programs than the
17 cost of furnishing such preventive services.

18 (b) REPORT.—Not later than January 1, 2003, the
19 Secretary shall submit to Congress a report on the study
20 conducted under subsection (a) that includes such rec-
21 ommendations as the Secretary determines appropriate for
22 legislative or administrative changes in tax-qualified pri-
23 vate health insurance plans and in Government health in-
24 surance plans (including medicaid) to encourage the provi-
25 sion of such preventive care services by such plans and

1 **Subtitle B—Development of Na-**
2 **tional Goals and Measures for**
3 **the Effective Management of**
4 **Chronic Illness**

5 **SEC. 211. ESTABLISHMENT OF A NEW OFFICE IN THE DE-**
6 **PARTMENT OF HEALTH AND HUMAN SERV-**
7 **ICES TO ENSURE COORDINATION OF CARE**
8 **FOR CHRONIC ILLNESS.**

9 (a) IN GENERAL.—There is established within the
10 Department of Health and Human Services an office to
11 be known as the Office of Integration and Coordination
12 of Care for Chronic Illness.

13 (b) MISSION STATEMENT.—The Office of Integration
14 and Coordination of Care for Chronic Illness shall ensure
15 the satisfactory implementation of the provisions of this
16 Act.

17 **SEC. 212. ESTABLISHMENT OF A NATIONAL DATABASE FOR**
18 **CHRONIC ILLNESS.**

19 (a) ESTABLISHMENT OF DATABASE.—The Secretary
20 of Health and Human Services shall develop a database
21 to be known as the “National Database for Serious and
22 Disabling Chronic Illness”. The purpose of the database
23 is—

24 (1) to generate accurate information about the
25 prevalence, demographics, health status, functional

1 status, financial status, support systems, and quality
2 of life of persons suffering from serious and dis-
3 abling chronic illnesses;

4 (2) to compile aggregate data on the utilization,
5 cost, and outcomes of chronic illness; and

6 (3) to enable the Secretary to set goals and
7 measure progress in reducing the cost to society of
8 improving care of the chronically ill.

9 (b) EFFECTIVE DATE.—The Secretary shall establish
10 the database referred to in subsection (a) by not later than
11 the date that is 18 months after the date of the enactment
12 of this Act.

13 **SEC. 213. ESTABLISHMENT OF NATIONAL GOALS TO RE-**
14 **DUCE THE PREVALENCE OF HIGH-COST**
15 **CHRONIC ILLNESS.**

16 The Secretary of Health and Human Services shall
17 establish targets for reducing the prevalence of the high-
18 est-cost and fastest-growing chronic illnesses.

19 (1) In 2005, the Secretary shall establish and
20 issue national goals for reducing the prevalence of
21 high-cost chronic care conditions. Every 5 years
22 thereafter, the Secretary shall issue new national
23 goals to reflect past progress.

24 (2) Each year starting in 2010, the Secretary
25 shall issue a report on the progress in meeting the

1 goals issued under paragraph (1), the reasons for
2 success or failure in meeting those goals, and the es-
3 timated savings achieved by reduced prevalence of
4 those conditions, including the relationship between
5 medicare spending and medicaid savings and the
6 cost-effectiveness of preventive benefits within and
7 across the medicare and medicaid programs.

8 (3) In establishing the national goal under
9 paragraph (1) for 2005, the Secretary shall give pri-
10 ority to achieving the maximum feasible reduction in
11 the chronic conditions that represent the largest pro-
12 portion of national health care expenditures and
13 shall consider the goals recommended by the Com-
14 mission established in section 101(b)(10).

15 **SEC. 214. ESTABLISHMENT OF QUALITY IMPROVEMENT,**
16 **MEDICAL ERROR REDUCTION AND OUT-**
17 **COMES GOALS.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services shall carry out the following requirements
20 as soon as practicable:

21 (1) Identify risk factors associated with pro-
22 gression of serious and disabling chronic illnesses,
23 and identify interventions for primary, secondary,
24 and tertiary prevention.

1 (2) Prior to January 1, 2005, conduct no less
2 than 5 patient-oriented research trials (PORTs) that
3 the Secretary determines will have the greatest and
4 most immediate impact on the largest number of
5 people with chronic illness.

6 (3) Develop disease prevention guidelines for
7 the highest-cost chronic diseases and disabilities,
8 measured by severity and prevalence.

9 (4) Develop disability-based outcome measures
10 that evaluate effectiveness in preventing, delaying, or
11 minimizing the progression of chronic diseases and
12 disabilities and associated comorbidities and loss of
13 independence on a longitudinal basis.

14 (b) **MEDICARE+CHOICE ORGANIZATIONS.**—For
15 years beginning on or after January 1, 2005, each
16 Medicare+Choice organization shall conduct on an annual
17 basis—

18 (1) at least 1 new continuous quality improve-
19 ment initiative involving chronic care focusing on de-
20 laying the progression of disability and preventing
21 the emergence of disease-related complications; or

22 (2) at least 1 new initiative to reduce prevent-
23 able medical errors involving chronic care.

1 **SEC. 215. DEVELOPMENT AND IMPLEMENTATION OF COM-**
2 **MON PATIENT ASSESSMENT INSTRUMENTS**
3 **ACROSS SETTINGS.**

4 (a) **ESTABLISHMENT OF STANDARD PATIENT AS-**
5 **SESSMENT INSTRUMENTS.**—The Secretary of Health and
6 Human Services, through negotiated rulemaking in ac-
7 cordance with subchapter III of chapter 5 of title 5,
8 United States Code, and in accordance with the require-
9 ments of this section, shall establish and implement stand-
10 ard patient assessment instruments under the medicare
11 program under title XVIII of the Social Security Act that
12 provide comparability of information and to the maximum
13 extent feasible, reduce the need for repeated evaluations
14 and data entry at each new site of service.

15 (b) **CONSULTATION.**—In establishing the standard
16 patient assessment instruments under subsection (a), the
17 Secretary shall consult with representatives of providers
18 of services, suppliers, and with appropriate organizations
19 and entities representing private sector entities to promote
20 the development and use of common sets of quality meas-
21 ures that represent the full spectrum of care obtained by
22 individuals entitled to benefits under the medicare pro-
23 gram under such title.

24 (c) **SOLE ASSESSMENT INSTRUMENTS.**—No later
25 than January 1, 2005, standard patient assessment in-
26 struments established under this section shall be the sole

1 patient assessment instrument utilized by the Secretary
2 of Health and Human Services with respect to items and
3 services furnished under the medicare and medicaid pro-
4 grams, and shall supersede any patient assessment instru-
5 ment or method utilized by the Secretary with respect to
6 such items and services.

7 **SEC. 216. DEVELOPMENT OF NATIONAL RESOURCE CEN-**
8 **TERS ON THE INTERNET FOR SERIOUS AND**
9 **DISABLING CHRONIC ILLNESS.**

10 (a) **IN GENERAL.**—The Agency of Healthcare Re-
11 search and Quality shall develop and make available in
12 electronic format an authoritative, reliable national re-
13 source center for serious and disabling chronic illnesses,
14 to be used by patients and their families that include infor-
15 mation necessary for patient education and facilitate self-
16 management. The resource center shall include informa-
17 tion for patients and health care providers on current clin-
18 ical guidelines that is, as of the date of the enactment of
19 this Act, available in the National Guidelines Clearing-
20 house maintained by the Agency.

21 (b) **NO FEE FOR USE OF INFORMATION.**—The Agen-
22 cy of Healthcare Research and Quality may not charge
23 a fee for the use of the national resource center developed
24 under subsection (a).

1 **Subtitle C—Payment Incentives for**
2 **Furnishing Quality Services to**
3 **the Chronically Ill**

4 **SEC. 221. BONUS PAYMENTS TO MEDICARE+CHOICE ORGA-**
5 **NIZATIONS IMPLEMENTING COMPREHENSIVE**
6 **PROGRAMS OF DISEASE AND DISABILITY**
7 **PREVENTION THAT ACHIEVE PREVENTION**
8 **GOALS ESTABLISHED BY THE SECRETARY.**

9 (a) **ESTABLISHMENT OF PERFORMANCE POOL AC-**
10 **COUNT.**—There is created within the Federal Supple-
11 mental Medical Insurance Trust Fund established by sec-
12 tion 1841 an account to be known as the “Performance
13 Bonus Pool Account” (in this section referred to as the
14 “Account”).

15 (b) **AMOUNTS IN ACCOUNT.**—

16 (1) **IN GENERAL.**—The Account shall consist of
17 the amounts deposited by the Secretary of Health
18 and Human Services that are attributable to reduc-
19 tions in payments to Medicare+Choice organizations
20 by reason of paragraph (2).

21 (2) **REDUCTIONS IN PAYMENTS TO**
22 **MEDICARE+CHOICE ORGANIZATIONS.**—For months
23 on occurring on or after January 1, 2005, the Sec-
24 retary shall reduce by 1 percent the annual
25 Medicare+Choice capitation rate under section

1 1853(e) of the Social Security Act (42 U.S.C.
2 1395w-23(e)) for Medicare+Choice organizations
3 offering Medicare+Choice plans.

4 (3) SEPARATION OF FUNDS.—Funds provided
5 under this part to the Account shall be kept sepa-
6 rate from all other funds within the Federal Supple-
7 mental Medical Insurance Trust Fund.

8 (c) PAYMENTS FROM ACCOUNT.—

9 (1) BONUS PAYMENTS TO ORGANIZATIONS
10 THAT MEET OR EXCEED CHRONIC ILLNESS TARGET
11 GOALS.—At the end of each year, beginning with
12 2005, the Secretary shall make payments from the
13 Account (in the aggregate of the total amount de-
14 posited in the Account during the year) to those
15 Medicare+Choice organizations offering items and
16 services under the Medicare+Choice plan in a man-
17 ner that meets or exceeds the chronic illness target
18 goals established in section 212 of the Chronic Ill-
19 ness Care Improvement Act of 2000.

20 (2) AMOUNT OF BONUS PAYMENT.—The
21 amount of a bonus payment under paragraph (1) to
22 a Medicare+Choice organization shall be weighted
23 for excellence in reduction in high-cost chronic con-
24 ditions under the Medicare+Choice plan, for further
25 delaying disability progression and improving health

1 outcomes, and by such other factors as the Secretary
2 determines appropriate under such target goals.

3 (d) **REPORT ON BONUS PAYMENTS TO PROVIDERS IN**
4 **FEE-FOR-SERVICE.**—Not later than January 1, 2002, the
5 Secretary shall submit to Congress a report containing
6 recommendations for legislative and administrative
7 changes under the medicare program to provide additional
8 payments for excellence in reduction in high-cost chronic
9 conditions to providers furnishing services to medicare
10 beneficiaries who are not enrolled under a
11 Medicare+Choice plan offered by a Medicare+Choice or-
12 ganization under part C of the medicare program.

13 **SEC. 222. INCREASED ATTENTION TO PAYMENT POLICIES**
14 **FOR THE CHRONICALLY ILL UNDER**
15 **MEDICARE+CHOICE.**

16 (a) **IN GENERAL.**—Section 511(b)(2) of the Medi-
17 care, Medicaid, and SCHIP Balanced Budget Refinement
18 Act of 1999 (42 U.S.C. 1395W–23 note) is amended by
19 adding at the end the following new subsection:

20 “(G) Suggestions for more accurately measuring the
21 costs of preventing, delaying, and managing chronic illness
22 and disability.”.

23 (b) **EFFECTIVE DATE.**—The amendment made by
24 subsection (a) shall take effect as if included in the enact-

1 ment of the Medicare, Medicaid, and SCHIP Balanced
2 Budget Refinement Act of 1999 (Public Law 106–113).

3 **SEC. 223. ASSURING ADEQUATE MANPOWER AND EXPER-**
4 **TISE FOR THE TREATMENT OF CHRONIC ILL-**
5 **NESS.**

6 (a) STUDY.—

7 (1) IN GENERAL.—The Secretary of Health and
8 Human Services shall conduct a study to evaluate
9 the need for additional physician and nonphysician
10 health care staff and expertise in the management of
11 chronic illness of medicare beneficiaries. To the ex-
12 tent that the Secretary determines that any physi-
13 cian and nonphysician health care staff and exper-
14 tise shortages exist, or may be likely to exist, the
15 Secretary shall evaluate methods to prevent short-
16 ages in physician and nonphysician health care staff
17 and expertise.

18 (2) EMPHASIS ON CERTAIN MATTERS.—Special
19 emphasis shall be given to studying strategies for
20 ensuring an adequate supply of allied health profes-
21 sionals (such as nurses) and paraprofessionals (such
22 as nurse aides). Strategies to be studied may
23 include—

24 (A) defining “health worker shortage
25 areas” to target Federal funds toward recruit-

1 ment and retention initiatives for professional
2 and paraprofessional workers in health care;

3 (B) loan forgiveness for registered nurses
4 and licensed practical nurses under the Public
5 Health Service Act;

6 (C) stipends for paraprofessionals to cover
7 training requirements for certified nursing as-
8 sistants;

9 (D) day care, transportation, housing, and
10 health insurance subsidies;

11 (E) tax credits for persons that remain
12 employed by providers in health professional
13 shortage areas for a specified period of time;

14 (F) tax incentives to support employees
15 who care for elders in their own homes; and

16 (G) salary subsidies for providers located
17 in areas with low unemployment levels, as de-
18 fined by the Secretary of Health and Human
19 Services in consultation with the Secretary of
20 Labor.

21 (b) REPORT.—Not later than January 1, 2003, the
22 Secretary shall submit to Congress a report on the study
23 conducted under subsection (a), and shall include any rec-
24 ommendations for legislation or administrative action to

1 prevent shortages in physician and nonphysician health
2 care staff and expertise.

3 (c) AUTHORITY TO ADJUST GME PAYMENTS.—

4 (1) IN GENERAL.—If the Secretary determines
5 that a shortage of physicians exists, or is likely to
6 exist, in a specialty or subspecialty of medicine that
7 has as a component the diagnosis and management
8 of chronic illness, then notwithstanding any provi-
9 sion of section 1886(h) of the Social Security Act
10 (42 U.S.C. 1395ww(h)) to the contrary—

11 (A) the Secretary may adjust, on a revenue
12 neutral basis, the graduate medical education
13 payment weight for approved medical residency
14 training programs in that specialty or sub-
15 specialty in order to encourage the movement of
16 additional medical residents into that specialty
17 or subspecialty, and

18 (B) the Secretary may increase the number
19 of residents in that specialty or subspecialty.

20 (2) EFFECTIVE DATE.—The provisions of para-
21 graph (1) shall apply with respect to cost reporting
22 periods beginning on or after October 1, 2002.

1 **TITLE III—DEVELOPMENT OF**
2 **PROTOTYPES OF INTEGRA-**
3 **TION AND COORDINATION OF**
4 **CARE FOR 2 CHRONIC ILL-**
5 **NESS SUBPOPULATIONS TO**
6 **BE EXPANDED IN 2007 TO ALL**
7 **SERIOUS AND DISABLING**
8 **CHRONIC ILLNESSES**

9 **SEC. 301. DISEASE MANAGEMENT SERVICES FOR SERIOUS**
10 **AND DISABLING CHRONIC ILLNESS.**

11 Title XVIII of the Social Security Act (42 U.S.C.
12 1395 et seq.) is amended by inserting after section 1888
13 the following new section:

14 “DISEASE MANAGEMENT SERVICES FOR SERIOUS AND
15 DISABLING CHRONIC ILLNESS

16 “SEC. 1889. (a) IMPLEMENTATION OF DISEASE
17 MANAGEMENT SERVICES PROGRAM.—

18 “(1) IN GENERAL.—The Secretary shall estab-
19 lish and implement a comprehensive program in ac-
20 cordance with the provisions of this section to pro-
21 vide for the coverage under this title of disease man-
22 agement services for serious and disabling chronic
23 illnesses furnished to eligible individuals described in
24 subsection (b), under such appropriate cir-
25 cumstances as the Secretary prescribes, by entities

1 designated by the Secretary with respect to diag-
2 noses that the Secretary determines may be helped
3 by such management. The program shall be known
4 as the National Initiative to Improve Chronic Illness
5 Care.

6 “(2) INITIAL PILOT PROJECTS.—

7 “(A) DIABETES MELLITUS; ALZ-
8 HEIMER’S.—Not later than 6 months after the
9 date of the termination of the National Com-
10 mission on Improving Chronic Illness Care (es-
11 tablished under section 101), the Secretary
12 shall establish and implement a pilot project to
13 provide for the coverage described in paragraph
14 (1) with respect to diabetes mellitus and an-
15 other pilot project to provide for such coverage
16 for Alzheimer’s disease.

17 “(B) DESIGNATION OF PILOT PROJECTS.—

18 The pilot project established under subpara-
19 graph (A) providing for coverage for diabetes
20 mellitus shall be known as the ‘National Diabe-
21 tes Pilot Initiative to Improve Chronic Illness
22 Care’. The pilot project established under sub-
23 paragraph (A) providing for coverage for Alz-
24 heimer’s disease shall be known as the ‘Na-

1 tional Alzheimer’s Disease Pilot Initiative to
2 Improve Chronic Illness Care’.

3 “(C) INITIAL REPORT TO CONGRESS ON
4 COSTS AND COST SAVINGS.—Not later than 2
5 years after the beginning of the pilot projects
6 under this paragraph, the Secretary shall sub-
7 mit to Congress a report on the impact of the
8 pilot projects on costs and savings under this
9 title, and in considering savings, shall include
10 impacts on quality of life for patients and their
11 families and costs avoided across settings and
12 over time.

13 “(3) NATIONAL INITIATIVE TO IMPROVE
14 CHRONIC ILLNESS CARE.—

15 “(A) IN GENERAL.—Not later than Janu-
16 ary 1, 2007, the Secretary shall expand the pro-
17 gram, based upon the prototype established for
18 the pilot projects under paragraph (2) and the
19 recommendations of the expert panel described
20 in subparagraph (B), to provide for the cov-
21 erage described in paragraph (1) for all serious
22 and disabling chronic illnesses, and those ill-
23 nesses that may potentially be serious and dis-
24 abling chronic illnesses, as determined by the
25 Secretary.

1 “(B) EXPERT PANEL DESCRIBED.—The
2 expert panel referred to in subparagraph (A) is
3 the expert panel commissioned under section
4 101(b)(6) of the Chronic Illness Care Improve-
5 ment Act of 2000 to analyze the experience and
6 outcomes of the initial pilot projects established
7 in paragraph (2) and to provide recommenda-
8 tions to the Secretary for use in the final devel-
9 opment of the National Initiative to Improve
10 Chronic Illness Care.

11 “(b) ADMINISTRATION BY CONTRACT.—Except as
12 otherwise specifically provided for in this section, the Sec-
13 retary may administer the program under this section as
14 follows:

15 “(1) IN GENERAL.—The Secretary may admin-
16 ister the program through a contract with a pro-
17 gram administrator in accordance with the provi-
18 sions of this subsection.

19 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-
20 TRACTS.—A contract under this subsection may, at
21 the Secretary’s discretion, relate to administration of
22 any or all of the programs or projects specified in
23 subsection (a). The Secretary may enter into such
24 contracts for a limited geographic area, or on a re-
25 gional or national basis.

1 “(3) ELIGIBLE CONTRACTORS.—The Secretary
2 may contract for the administration of the program
3 with—

4 “(A) an entity that, under a contract
5 under section 1816 or 1842, determines the
6 amount of and makes payments for health care
7 items and services furnished under this title; or

8 “(B) any other entity with substantial ex-
9 perience in managing the type of program con-
10 cerned.

11 “(4) CONTRACT AWARD, DURATION, AND RE-
12 NEWAL.—

13 “(A) IN GENERAL.—A contract under this
14 subsection shall be for an initial term of up to
15 three years, renewable for additional terms of
16 up to three years.

17 “(B) NONCOMPETITIVE AWARD AND RE-
18 NEWAL FOR ENTITIES ADMINISTERING PART A
19 OR PART B PAYMENTS.—The Secretary may
20 enter or renew a contract under this subsection
21 with an entity described in paragraph (3)(A)
22 without regard to the requirements of section 5
23 of title 41, United States Code.

24 “(5) APPLICABILITY OF FEDERAL ACQUISITION
25 REGULATION.—The Federal Acquisition Regulation

1 shall apply to program administration contracts
2 under this subsection.

3 “(6) PERFORMANCE STANDARDS.—The Sec-
4 retary shall establish performance standards for the
5 program administrator including, as applicable,
6 standards for the quality and cost-effectiveness of
7 the program administered, and such other factors as
8 the Secretary finds appropriate. The eligibility of en-
9 tities for the initial award, continuation, and renewal
10 of program administration contracts shall be condi-
11 tioned, at a minimum, on performance that meets or
12 exceeds such standards.

13 “(7) FUNCTIONS OF PROGRAM ADMINIS-
14 TRATOR.—A program administrator shall perform
15 any or all of the following functions, as specified by
16 the Secretary:

17 “(A) AGREEMENTS WITH INDIVIDUALS OR
18 ENTITIES FURNISHING HEALTH CARE ITEMS
19 AND SERVICES.—Determine the qualifications
20 of individuals or entities seeking to enter or
21 renew agreements to provide services under a
22 program specified in subsection (a), and as ap-
23 propriate enter or renew (or refuse to enter or
24 renew) such agreements on behalf of the Sec-
25 retary.

1 “(B) ESTABLISHMENT OF PAYMENT
2 RATES.—Negotiate or otherwise establish, sub-
3 ject to the Secretary’s approval, payment rates
4 for covered health care items and services.

5 “(C) PAYMENT OF CLAIMS OR FEES.—Ad-
6 minister payments for health care items or serv-
7 ices furnished under any such program.

8 “(D) PAYMENT OF BONUSES.—Using such
9 guidelines as the Secretary shall establish, and
10 subject to the approval of the Secretary, make
11 bonus payments as described in subsection
12 (c)(2)(A)(ii) to individuals and entities fur-
13 nishing items or services for which payment
14 may be made under any such program.

15 “(E) LIST OF PROGRAM PARTICIPANTS.—
16 Maintain and regularly update a list of individ-
17 uals or entities with agreements to provide
18 health care items and services under any such
19 program, and ensure that such list, in electronic
20 and hard copy formats, is readily available, as
21 applicable, to—

22 “(i) individuals residing in the service
23 area who are entitled to benefits under
24 part A or enrolled in the program under
25 part B;

1 “(ii) the entities responsible under
2 sections 1816 and 1842 for administering
3 payments for health care items and serv-
4 ices furnished; and

5 “(iii) individuals and entities pro-
6 viding health care items and services in the
7 service area.

8 “(F) BENEFICIARY ENROLLMENT.—Deter-
9 mine eligibility of individuals to enroll under a
10 program specified in subsection (a) and provide
11 enrollment-related services (but only if the Sec-
12 retary finds that the program administrator has
13 no conflict of interest caused by a financial re-
14 lationship with any individual or entity fur-
15 nishing items or services for which payment
16 may be made under any such program, or any
17 other conflict of interest with respect to such
18 function).

19 “(G) OVERSIGHT.—Monitor the compli-
20 ance of individuals and entities with agreements
21 under any such program with the conditions of
22 participation.

23 “(H) ADMINISTRATIVE REVIEW.—Conduct
24 reviews of adverse determinations specified in
25 subparagraph (A).

1 “(I) REVIEW OF MARKETING MATE-
2 RIALS.—Conduct a review of marketing mate-
3 rials proposed by an individual or entity fur-
4 nishing services under any such program.

5 “(J) ADDITIONAL FUNCTIONS.—Perform
6 such other functions as the Secretary may
7 specify.

8 “(8) LIMITATION OF LIABILITY.—The provi-
9 sions of section 1157(b) shall apply with respect to
10 activities of contractors and their officers, employ-
11 ees, and agents under a contract under this sub-
12 section.

13 “(9) INFORMATION SHARING.—Notwithstanding
14 section 1106 and section 552a of title 5, United
15 States Code, the Secretary may disclose to an entity
16 with a program administration contract under this
17 subsection such information (including medical in-
18 formation) on individuals receiving health care items
19 and services under the program as the entity may
20 require to carry out its responsibilities under the
21 contract.

22 “(c) RULES APPLICABLE TO PROGRAM ADMINISTRA-
23 TION CONTRACTS.—

24 “(1) RECORDS, REPORTS, AND AUDITS.—The
25 Secretary is authorized to require individuals and

1 entities with agreements to provide health care items
2 or services under programs specified under sub-
3 section (a), and entities with program administration
4 contracts under subsection (b), to maintain adequate
5 records, to afford the Secretary access to such
6 records (including for audit purposes), and to fur-
7 nish such reports and other materials (including au-
8 dited financial statements and performance data) as
9 the Secretary may require for purposes of implemen-
10 tation, oversight, and evaluation of such program
11 and of individuals' and entities' effectiveness in per-
12 formance of such agreements or contracts.

13 “(2) BONUSES.—Notwithstanding any other
14 provision of law, but subject to subparagraph
15 (B)(ii), the Secretary may make bonus payments
16 under a program specified in subsection (a) from the
17 Federal Hospital Insurance and Federal Supple-
18 mentary Medical Insurance Trust Funds in amounts
19 that do not exceed 50 percent of the savings to such
20 Trust Funds attributable to such programs in
21 amounts authorized under such program, in accord-
22 ance with the following:

23 “(A) PAYMENTS TO PROGRAM ADMINIS-
24 TRATORS.—The Secretary may make bonus

1 payments under each program specified in sub-
2 section (a) to program administrators.

3 “(B) PAYMENTS TO INDIVIDUALS AND EN-
4 TITIES FURNISHING SERVICES.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), the Secretary may make bonus pay-
7 ments to individuals or entities furnishing
8 items or services for which payment may
9 be made under the programs under sub-
10 section (a), or may authorize a program
11 administrator to make such bonus pay-
12 ments in accordance with such guidelines
13 as the Secretary shall establish and subject
14 to the Secretary’s approval.

15 “(ii) LIMITATIONS.—The Secretary
16 may limit bonus payments under clause (i)
17 to particular service areas, types of individ-
18 uals or entities furnishing items or services
19 under a program, or kinds of items or
20 services, and may condition such payments
21 on the achievement of such standards re-
22 lated to efficiency, improvement in proc-
23 esses or outcomes of care, or such other
24 factors as the Secretary determines to be
25 appropriate.

1 “(iii) RURAL AREAS.—In a health
2 professional shortage area located in a
3 rural or frontier county in which the provi-
4 sion of comprehensive disease management
5 for serious and disabling chronic illness is
6 difficult due to a shortage in health profes-
7 sional providing items and services under
8 this title, the Secretary may provide for
9 bonus payments under this section for
10 rural disease management services fur-
11 nished by such physician or other health
12 care provider to medicare beneficiaries.

13 “(3) ANTIDISCRIMINATION LIMITATION.—

14 “(A) IN GENERAL.—The Secretary shall
15 not enter into an agreement with an individual
16 or entity to provide health care items or serv-
17 ices under a program specified under subsection
18 (a), or with an entity to administer such a pro-
19 gram, unless such individual or entity guaran-
20 tees that it will not deny, limit, or condition the
21 coverage or provision of benefits under such
22 program, for individuals eligible to be enrolled
23 under such program, based on any health sta-
24 tus-related factor described in section
25 2702(a)(1) of the Public Health Service Act.

1 “(B) CONSTRUCTION.—Subparagraph (A)
2 shall not be construed to prohibit such indi-
3 vidual or entity from taking any action explic-
4 itly authorized by the provisions of this section.

5 “(d) INDIVIDUALS ELIGIBLE FOR DISEASE MANAGE-
6 MENT SERVICES FOR CHRONIC ILLNESS.—No individual
7 shall be eligible for enrollment in a disease management
8 program under this section unless the Secretary finds the
9 following with respect to the individual:

10 “(1) NATIONAL DIABETES PILOT INITIATIVE TO
11 IMPROVE CHRONIC ILLNESS CARE.—With respect to
12 individuals participating in the National Diabetes
13 Pilot Initiative To Improve Chronic Illness Care, the
14 individual has been diagnosed with diabetes mellitus.

15 “(2) NATIONAL ALZHEIMER’S DISEASE PILOT
16 INITIATIVE TO IMPROVE CHRONIC ILLNESS CARE.—
17 With respect to individuals participating in the Na-
18 tional Alzheimer’s Disease Pilot Initiative To Im-
19 prove Chronic Illness Care, the individual has been
20 diagnosed with Alzheimer’s disease.

21 “(3) NATIONAL INITIATIVE TO IMPROVE
22 CHRONIC ILLNESS CARE.—With respect to individ-
23 uals participating in the National Initiative To Im-
24 prove Chronic Illness Care, as follows:

1 “(A) DIAGNOSIS.—The individual has been
2 diagnosed with congestive heart failure, chronic
3 obstructive pulmonary disease, diabetes, Alz-
4 heimer’s disease and other progressive demen-
5 tias, Parkinson’s disease, multiple sclerosis, de-
6 pression, or any other diagnosis, if the Sec-
7 retary has determined with respect to such di-
8 agnoses that there is evidence that the provision
9 of disease management services, over clinically
10 relevant time periods, to cohorts of individuals
11 with such diagnoses can reasonably be expected
12 to improve processes or outcomes of health care
13 (or in the case of individuals with advanced ill-
14 ness, improved quality of life) for the medicare
15 population and to have some (partial or total)
16 offsetting savings in this title or other Federal
17 programs.

18 “(B) ADDITIONAL FACTORS.—The Sec-
19 retary may establish such additional clinical cri-
20 teria for eligibility for enrollment under such a
21 disease management program as the Secretary
22 determines appropriate, including certain clin-
23 ical characteristics or conditions of the indi-
24 vidual, certain patterns of utilization of the in-
25 dividual, or other factors indicating the need for

1 and potential effectiveness of disease manage-
2 ment for the individual.

3 “(e) PROCEDURES TO FACILITATE ENROLLMENT.—

4 The Secretary shall develop and implement procedures de-
5 signed to facilitate enrollment of eligible individuals in the
6 programs under this section.

7 “(f) INTEGRATION AND COORDINATION OF CARE FOR
8 CHRONIC ILLNESS.—The Secretary shall develop an inte-
9 grated and coordinated health care delivery system for se-
10 rious and disabling chronic illness based on the following
11 components:

12 “(1) A chronic care network of providers char-
13 acterized by coordination of medicare, medicaid and
14 other programs or agencies that provide directly or
15 otherwise for the care of patients with serious and
16 disabling chronic illness.

17 “(2) A payment model that aligns the financial
18 incentives of the health care providers of the chron-
19 ically ill in order to reduce disincentives to providing
20 high quality care with improved cost effectiveness
21 and simplicity in billing for providers and bene-
22 ficiaries. Under the payment model, the Secretary
23 may waive any other provision of this title that re-
24 stricts access to the most appropriate care in the
25 lowest cost setting, such as the 3-day hospitalization

1 rule before a beneficiary is eligible for skilled nurs-
2 ing facility care, the homebound definition as a bar-
3 rier to care at an adult day care facility, and such
4 other provisions as the Secretary determines appro-
5 priate.

6 “(3) An administrative model that functions to
7 efficiently match health care services to the range of
8 health care needs and reduces unnecessary, duplica-
9 tive services and paperwork.

10 “(4) Integrated information systems, including
11 integrated administrative and financial data systems
12 as well as a common medical record for participating
13 chronic care enrollees that is used by chronic care
14 network providers and continuously supplemented
15 and updated over time.

16 “(5) Ongoing evaluation of cost effectiveness of
17 services based on longitudinal and aggregate system
18 costs.

19 “(g) DISEASE MANAGEMENT FOR CHRONIC ILLNESS
20 SERVICES.—

21 “(1) IN GENERAL.— Subject to the cost-effec-
22 tiveness standards established under subsection
23 (b)(6), disease management services provided to an
24 individual under this section shall include the fol-
25 lowing:

1 “(A) Initial and periodic health screening
2 and assessment.

3 “(B) Management that provides a com-
4 prehensive range of services to the chronically
5 ill, based on best practices and established clin-
6 ical guidelines (including coordination with
7 other providers), and referral for medical and
8 other health services related to the managed di-
9 agnosis.

10 “(C) Case management to facilitate con-
11 tinuity of care and patient adherence to the
12 plan of care with provisions for reimbursement
13 for case management.

14 “(D) Monitoring and control of medica-
15 tions.

16 “(E) Interdisciplinary, collaborative care
17 by a health care team based on efficient com-
18 munication between the various health care pro-
19 viders.

20 “(F) Preventive care designed to foster
21 early recognition of symptoms, reduce the prev-
22 alence of comorbidities, and reduce or delay the
23 onset and progression of disability and depend-
24 ence.

1 “(G) Quality improvement and enhance-
2 ment of patient safety with reduction of pre-
3 ventable medical errors.

4 “(H) Health care delivery that fosters self-
5 management, patient goalsetting, patient em-
6 powerment, self-reliance, dignity, and independ-
7 ence.

8 “(I) Education and counseling for patient
9 and family directed at issues of coping and ad-
10 justment, practical concerns, spiritual needs,
11 and others that serve the distinct needs of the
12 patient and family at each stage of illness, in-
13 cluding the time of diagnosis, early illness, mid-
14 dle stages of illness, and advanced illness.

15 “(J) Nursing or other health professional
16 home visits, as appropriate.

17 “(K) Providing access for electronic con-
18 sultations with physicians or other appropriate
19 medical professionals, including 24-hour avail-
20 ability for emergency consultations; in devel-
21 oping such electronic consultations, the Sec-
22 retary shall draw on the results, to the extent
23 available, of section 4207 of the Balanced
24 Budget Act.

1 “(L) Managing and facilitating the transi-
2 tion to other care arrangements in preparation
3 for termination of the disease management en-
4 rollment.

5 “(M) Such other services for which pay-
6 ment would not otherwise be made under this
7 title, as the Secretary shall determine to be ap-
8 propriate.

9 “(2) VARIATIONS IN SERVICE PACKAGES.—The
10 type and combinations of disease management serv-
11 ices furnished under agreements under this section
12 may vary (as permitted or required by the Sec-
13 retary) according to the types of diagnoses, condi-
14 tions, patient profiles being managed, expertise of
15 the disease management organization, geographic
16 isolation, and other factors the Secretary finds ap-
17 propriate.

18 “(h) ENROLLMENT OF INDIVIDUALS IN DISEASE
19 MANAGEMENT PROGRAMS.—

20 “(1) EFFECTIVE DATE AND DURATION.—En-
21 rollment of an individual in the program under this
22 section shall remain in effect for a period to be de-
23 termined by the Secretary and shall be automatically
24 renewed for additional periods, unless terminated in

1 accordance with such procedures as the Secretary
2 shall establish by regulation.

3 “(2) LIMITATION OF REENROLLMENT.—The
4 Secretary may establish limits on an individual’s eli-
5 gibility to reenroll in the program under this section
6 if the individual has disenrolled more than once dur-
7 ing a specified time period.

8 “(i) DISEASE MANAGEMENT REQUIREMENT.—Not-
9 withstanding any other provision of this title, the Sec-
10 retary may provide that an individual enrolled in the pro-
11 gram under this section may be entitled to payment under
12 this title for any specified health care items or services
13 only if the items or services have been furnished by the
14 disease management organization, or coordinated through
15 the disease management services program. Under such
16 provision, the Secretary shall prescribe exceptions for
17 emergency medical services as described in section
18 1852(d)(3), and other exceptions determined by the Sec-
19 retary for the delivery of timely and needed care.

20 “(j) AGREEMENT WITH DISEASE MANAGEMENT
21 PROVIDERS.—

22 “(1) ENTITIES ELIGIBLE.—Entities qualified to
23 enter into agreements with the Secretary for the
24 provision of disease management services under this
25 section include entities that have demonstrated the

1 ability to meet the performance standards and other
2 criteria established by the Secretary with respect
3 to—

4 “(A) the management of each diagnosis
5 and condition with respect to which the entity,
6 if designated, would furnish disease manage-
7 ment services under this section; and

8 “(B) the implementation of each disease
9 management approach that the entity, if des-
10 ignated, would implement under this section.

11 “(2) CONDITIONS OF PARTICIPATION.—In order
12 to be eligible to provide disease management services
13 under this section, an entity shall—

14 “(A) have in effect an agreement with the
15 Secretary setting forth such obligations of the
16 entity as a disease management organization
17 under this section as the Secretary shall pre-
18 scribe;

19 “(B) meet the standards established by the
20 Secretary under subsection (k); and

21 “(C) meet such other conditions as the
22 Secretary may establish.

23 “(3) SECRETARY’S OPTION FOR NONCOMPETI-
24 TIVE DESIGNATION.—The Secretary may designate
25 an entity to provide disease management services

1 under this section without regard to the require-
2 ments of section 5 of title 41, United States Code.

3 “(k) QUALITY STANDARDS.—The Secretary shall es-
4 tablish standards for, and procedures for assessing, the
5 quality of care provided by disease management organiza-
6 tions under this section, which shall include—

7 “(1) performance standards with respect to the
8 processes or outcomes of health care or the health
9 status of enrolled individuals, including procedures
10 for establishing a baseline and measuring changes in
11 health care processes or health outcomes with re-
12 spect to managed diseases or health conditions;

13 “(2) a requirement that the organization meet
14 such licensure and other accreditation standards as
15 the Secretary may find appropriate; and

16 “(3) such other quality standards, including pa-
17 tient satisfaction, as the Secretary may find appro-
18 priate.

19 “(l) PAYMENT.—The Secretary may negotiate or oth-
20 erwise establish payment terms and rates for the provision
21 of services under the program under this section, and
22 shall, to the extent practicable, base such payment terms
23 and rates methodology on payment methodologies estab-
24 lished under this title.

1 “(m) DEFINITION OF SERIOUS AND DISABLING
2 CHRONIC ILLNESS.—In this section, the term “serious
3 and disabling chronic condition’ means one or more bio-
4 logical or physical conditions which are likely to last for
5 an unspecified period of time, or for the duration of a per-
6 son’s life, for which there is no known cure, and which
7 may affect an individual’s ability to carry out basic activi-
8 ties of daily living, instrumental activities of daily living,
9 or both. Such conditions include the following:

10 “(1) Alzheimer’s Disease and related disorders.

11 “(2) Arthritis.

12 “(3) Cancer.

13 “(4) Cerebrovascular disease.

14 “(5) Diabetes.

15 “(6) Emphysema and bronchitis (including
16 chronic obstructive pulmonary disease.

17 “(7) Hypertension.

18 “(8) Ischemic heart disease.

19 “(9) Multiple sclerosis.

20 “(10) Parkinson’s disease.

21 “(11) Peripheral vascular disease.

22 “(12) Renal disease.”.

23 (b) COVERAGE OF DISEASE MANAGEMENT SERVICES
24 AS A PART B MEDICAL SERVICE.—

1 (1) IN GENERAL.—Section 1861(s) of the So-
2 cial Security Act (42 U.S.C. 1395x(s)), as amended
3 by section 201, is further amended—

4 (A) by redesignating paragraphs (17) and
5 (18) as paragraphs (18) and (19), respectively;

6 (B) by striking “and” at the end of para-
7 graph (15);

8 (C) by striking the period at the end of
9 paragraph (16) and inserting “and”; and

10 (D) by inserting after paragraph (16) the
11 following new paragraph:

12 “(17) disease management services furnished in
13 accordance with section 1889.”.

14 (2) PART B COINSURANCE AND DEDUCTIBLE
15 NOT APPLICABLE TO DISEASE MANAGEMENT SERV-
16 ICES.—

17 (A) COINSURANCE.—Section 1833(a)(1) of
18 the Social Security Act (42 U.S.C. 1395l(a)(1))
19 is amended—

20 (i) by striking “and” before “(S)”;

21 and

22 (ii) by inserting before the semicolon
23 at the end the following: “, and (T) with
24 respect to disease management services de-
25 scribed in section 1861(s)(16), the

1 amounts paid shall be 100 percent of the
2 payment amounts established under section
3 1889”.

4 (B) DEDUCTIBLE.—The first sentence of
5 section 1833(b) of the Social Security Act (42
6 U.S.C. 1395l(b)) is amended—

7 (i) by striking “and” before “(6)”;

8 and

9 (ii) by inserting before the period the
10 following: “, and (7) such deductible shall
11 not apply with respect to disease manage-
12 ment services (as described in section
13 1861(s)(16))”.

14 (3) CONFORMING AMENDMENTS.—Sections
15 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of
16 the Social Security Act (42 U.S.C. 1395aa(a),
17 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)), as
18 amended by section 201(a)(2), are each further
19 amended by striking “paragraphs (17) and (18)”
20 each place it appears and inserting “paragraphs
21 (18) and (19)”.

22 (c) ENROLLMENT.—

23 (1) IN GENERAL.—To carry out the provisions
24 of section 1889 of the Social Security Act, as added
25 by subsection (a), the Secretary of Health and

1 Human Services shall carry out a national public re-
2 lations and enrollment effort aimed at both providers
3 and consumers of health care to ensure widespread
4 awareness of the importance of serious and disabling
5 chronic illness management and the services avail-
6 able under section 1889 to initiate—

7 (A) in 2002, the National Diabetes Pilot
8 Initiative to Improve Chronic Illness Care and
9 the National Alzheimer’s Disease Pilot Initia-
10 tive to Improve Chronic Illness Care, estab-
11 lished in subsection (a)(2) of such section; and

12 (B) in 2006, the National Initiative to Im-
13 prove Chronic Illness Care, established in sub-
14 section (a)(3) of such section.

15 (2) AUTHORIZATION OF APPROPRIATIONS.—

16 There are authorized to be appropriated to the Sec-
17 retary of Health and Human Services in appropriate
18 part from the Federal Hospital Insurance and Fed-
19 eral Supplementary Medical Insurance Trust Funds
20 such sums as are necessary to carry out the enroll-
21 ment effort under paragraph (1).

1 **TITLE IV—INTEGRATING MEDI-**
2 **CARE AND MEDICAID FOR**
3 **DUAL ELIGIBLES**

4 **SEC. 401. PROVISION OF WAIVER AUTHORITY TO SERVE**
5 **DUAL ELIGIBLES MORE EFFICIENTLY.**

6 (a) **MEDICARE FEE-FOR-SERVICE.—**

7 (1) **IN GENERAL.—**Title XVIII of the Social Se-
8 curity Act is amended by adding at the end the fol-
9 lowing new section:

10 “**CLARIFICATION OF WAIVER AUTHORITY TO COORDINATE**
11 **AND INTEGRATE SERVICES AND ADMINISTRATION**
12 **UNDER THIS TITLE AND TITLE XIX**

13 “**SEC. 1897. (a) IN GENERAL.—**A State, health plan,
14 or provider may submit to the Secretary a request to waive
15 requirements of this title to permit States to enhance the
16 coordination and integration of items and services and ad-
17 ministration provided under this title with items and serv-
18 ices provided under title XIX.

19 “**(b) DEADLINE FOR ACTION ON WAIVER.—**The Sec-
20 retary shall approve, deny, or request additional informa-
21 tion for a request for waiver submitted under subsection
22 (a) by not later than 90 days after the receipt of such
23 submission.

24 “**(c) COORDINATION AND INTEGRATION OF ITEMS**
25 **AND SERVICES DESCRIBED.—**The coordination and inte-

1 gration of items and services referred to in subsection (a)
2 may include the following:

3 “(1) A process for unified enrollment under
4 both titles.

5 “(2) A unified quality improvement program.

6 “(3) A unified grievance and appeals process.

7 “(4) Unified provider and payer reporting re-
8 quirements.

9 “(5) Alternative payment methodologies under
10 this title, including modified risk adjusters and risk
11 sharing approaches.

12 “(d) LIMITATION.—

13 “(1) IN GENERAL.—The Secretary shall not
14 grant a waiver under this section unless the Sec-
15 retary determines that services furnished under the
16 waiver—

17 “(A) are offered to an individual for which
18 coverage for items and services is provided for
19 under this title and title XIX; and

20 “(B) are cost effective.

21 “(2) COST EFFECTIVE DEFINED.—For pur-
22 poses of paragraph (1), the term ‘cost effective’
23 means that services offered under a waiver granted
24 by the Secretary under this section do not result, in
25 the aggregate, in greater combined payments under

1 this title and title XIX for such services than the
2 combined payments that would have been made
3 under such titles on a fee-for-service basis to an ac-
4 tuarially equivalent population group.”.

5 (2) EFFECTIVE DATE.—The amendment made
6 by paragraph (1) shall take effect January 1, 2001.

7 (b) MEDICAID.—

8 (1) IN GENERAL.—Section 1915(a) of the So-
9 cial Security Act (42 U.S.C. 1396n(a)) is
10 amended—

11 (A) by striking “or” at the end of para-
12 graph (1);

13 (B) by striking the period at the end of
14 paragraph (2) and adding “or”; and

15 (C) by adding at the end the following new
16 paragraph:

17 “(3) consistent with the provisions of subsection
18 (i) has entered into a contract with an organization
19 to provide care and services, which may include care
20 and services in addition to those offered under the
21 State plan, to individuals—

22 “(A) who are eligible for medical assist-
23 ance,

24 “(B) who elect to obtain such care and
25 services from such organization, and

1 “(C) who are at least 65 years of age or
2 have a disability or a serious and disabling
3 chronic illness, including individuals who are
4 also eligible for health insurance benefits under
5 title XVIII.”.

6 (2) REQUIREMENTS.—Section 1915 of the So-
7 cial Security Act (42 U.S.C. 1396n) is amended by
8 adding at the end the following new subsection:

9 “(i) For purposes of contracts entered into under
10 subsection (a)(3), the following provisions apply:

11 “(1) For purposes of payments to States for
12 medical assistance under this title, individuals who
13 are eligible to receive care and services under sub-
14 section (a)(3) and who meet the income and re-
15 source eligibility requirements of individuals who are
16 eligible for medical assistance under section
17 1902(a)(10)(II)(ii)(VI) shall be treated as individ-
18 uals described in such section during enrollment
19 with an organization under such subsection.

20 “(2) Section 1924 applies to individuals receiv-
21 ing care and services under subsection (a)(3), and in
22 applying such section under subsection (a)(3), the
23 term ‘institutionalized spouse’ means an individual—

24 “(A) who is in a medical institution or
25 nursing facility or who (at the option of the

1 State) is described in section
2 1902(a)(10)(II)(ii)(VI), and

3 “(B) whose spouse is not in a medical in-
4 stitution or nursing facility.

5 “(3) A State may seek a waiver under title
6 XVIII, to integrate care and services furnished
7 under this title with items and services furnished
8 under title XVIII.

9 “(4) Care and services provided under sub-
10 section (a)(3) shall be cost effective, determined as
11 follows:

12 “(A) In the case of a program imple-
13 mented under subsection (a)(3) with no cor-
14 responding waiver under title XVIII, the aggre-
15 gate medical assistance payments to the organi-
16 zation for a defined scope of care and services
17 furnished to beneficiaries may not exceed the
18 medical assistance costs of providing those
19 same services on a fee-for-service basis to an
20 actuarially equivalent population.

21 “(B) In the case of a program imple-
22 mented under subsection (a)(3) with a waiver
23 under title XVIII, services offered do not result,
24 in the aggregate, in greater combined payments
25 under this title and title XVIII for such services

1 than the combined payments that would have
2 been made under such titles on a fee-for-service
3 basis to an actuarially equivalent population
4 group.”.

○