

108TH CONGRESS
1ST SESSION

S. 1179

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

IN THE SENATE OF THE UNITED STATES

JUNE 4, 2003

Mr. ROCKEFELLER introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

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

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

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

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

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

Sec. 1. Short title; table of contents.

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

Subtitle A—Improving Access to Preventive Services

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

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

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

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

Subtitle B—Medicare Coverage for Care Coordination and Assessment Services

Sec. 111. Care coordination and assessment services.

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

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

Subtitle C—Additional Provisions

Sec. 121. Review of coverage standards.

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

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

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

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

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

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

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

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

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

12 “(3) Pneumococcal, influenza, and hepatitis B
13 vaccines and administration described in section
14 1861(s)(10).

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

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

20 “(6) Bone mass measurement (as defined in
21 section 1861(rr)(1)).

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

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

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

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

5 (b) WAIVER OF COINSURANCE.—

6 (1) IN GENERAL.—Section 1833(a)(1)(B) of the
7 Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is
8 amended to read as follows: “(B) with respect to
9 preventive health items and services described in
10 subsection (p), the amounts paid shall be 100 per-
11 cent of the fee schedule or other basis of payment
12 under this title for the particular item or service,”.

13 (2) ELIMINATION OF COINSURANCE IN OUT-
14 PATIENT HOSPITAL SETTINGS.—The third sentence
15 of section 1866(a)(2)(A) of the Social Security Act
16 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-
17 ing after “1861(s)(10)(A)” the following: “, preven-
18 tive health items and services described in section
19 1833(p),”.

20 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—
21 Section 1833(b)(1) of the Social Security Act (42 U.S.C.
22 1395l(b)(1)) is amended to read as follows: “(1) such de-
23 ductible shall not apply with respect to preventive health
24 items and services described in subsection (p),”.

1 (d) ADDING “LANCET” TO DEFINITION OF DME.—
2 Section 1861(n) of the Social Security Act (42 U.S.C.
3 1395x(n)) is amended by striking “blood-testing strips
4 and blood glucose monitors” and inserting “blood-testing
5 strips, lancets, and blood glucose monitors”.

6 (e) CONFORMING AMENDMENTS.—

7 (1) ELIMINATION OF COINSURANCE FOR CLIN-
8 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs
9 (1)(D)(i) and (2)(D)(i) of section 1833(a) of the So-
10 cial Security Act (42 U.S.C. 1395l(a)) are each
11 amended by inserting “or which are described in
12 subsection (p)” after “assignment-related basis”.

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

19 (3) ELIMINATION OF DEDUCTIBLES AND COIN-
20 SURANCE FOR COLORECTAL CANCER SCREENING
21 TESTS.—Section 1834(d) of the Social Security Act
22 (42 U.S.C. 1395m(d)) is amended—

23 (A) in paragraph (2)(C)—

24 (i) by striking “(C) FACILITY PAY-
25 MENT LIMIT.—” and all that follows

1 through “Notwithstanding subsections”
2 and inserting the following:

3 “(C) FACILITY PAYMENT LIMIT.—Notwith-
4 standing subsections”;

5 (ii) by striking “(I) in accordance”
6 and inserting the following:

7 “(i) in accordance”;

8 (iii) by striking “(II) are performed”
9 and all that follows through “payment
10 under” and inserting the following:

11 “(ii) are performed in an ambulatory
12 surgical center or hospital outpatient de-
13 partment,

14 payment under”; and

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

16 (B) in paragraph (3)(C)—

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

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

23 (ii) by striking clause (ii).

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

4 **SEC. 102. INSTITUTE OF MEDICINE MEDICARE PREVEN-**
5 **TION BENEFIT STUDY AND REPORT.**

6 (a) STUDY.—

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

10 (A) conduct a comprehensive study of cur-
11 rent literature and best practices in the field of
12 health promotion and disease prevention among
13 medicare beneficiaries, including the issues de-
14 scribed in paragraph (2); and

15 (B) submit the report described in sub-
16 section (b).

17 (2) ISSUES STUDIED.—The study required
18 under paragraph (1) shall include an assessment
19 of—

20 (A) whether each health promotion and
21 disease prevention benefit covered under the
22 medicare program is medically effective (as de-
23 fined in subsection (d)(3));

1 (B) utilization by medicare beneficiaries of
2 such benefits (including any barriers to or in-
3 centives to increase utilization);

4 (C) quality of life issues associated with
5 such benefits; and

6 (D) whether health promotion and disease
7 prevention benefits that are not covered under
8 the medicare program that would affect all
9 medicare beneficiaries are likely to be medically
10 effective (as so defined).

11 (b) REPORTS.—

12 (1) THREE-YEAR REPORT.—On the date that is
13 3 years after the date of enactment of this Act, and
14 each successive 3-year anniversary thereafter, the
15 Institute of Medicine of the National Academy of
16 Sciences shall submit to the President a report that
17 contains—

18 (A) a detailed statement of the findings
19 and conclusions of the study conducted under
20 subsection (a); and

21 (B) the recommendations for legislation
22 described in paragraph (3).

23 (2) INTERIM REPORT BASED ON NEW GUIDE-
24 LINES.—If the United States Preventive Services
25 Task Force or the Task Force on Community Pre-

1 preventive Services establishes new guidelines regarding
2 preventive health benefits for medicare beneficiaries
3 more than 1 year prior to the date that a report de-
4 scribed in paragraph (1) is due to be submitted to
5 the President, then not later than 6 months after
6 the date such new guidelines are established, the In-
7 stitute of Medicine of the National Academy of
8 Sciences shall submit to the President a report that
9 contains a detailed description of such new guide-
10 lines. Such report may also contain recommenda-
11 tions for legislation described in paragraph (3).

12 (3) RECOMMENDATIONS FOR LEGISLATION.—
13 The Institute of Medicine of the National Academy
14 of Sciences, in consultation with the United States
15 Preventive Services Task Force and the Task Force
16 on Community Preventive Services, shall develop
17 recommendations in legislative form that—

18 (A) prioritize the preventive health benefits
19 under the medicare program; and

20 (B) modify such benefits, including adding
21 new benefits under such program, based on the
22 study conducted under subsection (a).

23 (c) TRANSMISSION TO CONGRESS.—

24 (1) IN GENERAL.—Subject to paragraph (2), on
25 the day that is 6 months after the date on which the

1 report described in paragraph (1) of subsection (b)
2 (or paragraph (2) of such subsection if the report
3 contains recommendations in legislative form de-
4 scribed in subsection (b)(3)) is submitted to the
5 President, the President shall transmit the report
6 and recommendations to Congress.

7 (2) REGULATORY ACTION BY THE SECRETARY
8 OF HEALTH AND HUMAN SERVICES.—If the Sec-
9 retary of Health and Human Services has exercised
10 the authority under section 103(a) to adopt by regu-
11 lation one or more of the recommendations under
12 subsection (b)(3), the President shall only submit to
13 Congress those recommendations under subsection
14 (b)(3) that have not been adopted by the Secretary.

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

19 (A) to both Houses of Congress on the
20 same day;

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

23 (C) to the Secretary of the Senate if the
24 Senate is not in session.

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

5 (1) subject to peer review;

6 (2) described in scientific journals; and

7 (3) determined to achieve an intended goal
8 under normal programmatic conditions.

9 **SEC. 103. AUTHORITY TO ADMINISTRATIVELY PROVIDE**
10 **FOR COVERAGE OF ADDITIONAL PREVEN-**
11 **TIVE BENEFITS.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services may by regulation adopt any or all of
14 the legislative recommendations developed by the Institute
15 of Medicine of the National Academy of Sciences, in con-
16 sultation with the United States Preventive Services Task
17 Force and the Task Force on Community Preventive Serv-
18 ices in a report under section 102(b)(3) (relating to
19 prioritizing and modifying preventive health benefits
20 under the medicare program and the addition of new pre-
21 ventive benefits), consistent with subsection (b).

22 (b) ELIMINATION OF COST-SHARING.—With respect
23 to items and services furnished under the medicare pro-
24 gram that the Secretary has incorporated by regulation
25 under subsection (a), the provisions of section 1833(p) of

1 the Social Security Act (relating to elimination of cost-
 2 sharing for preventive benefits), as added by section
 3 101(a), shall apply to those items and services in the same
 4 manner as such section applies to the items and services
 5 described in paragraphs (1) through (10) of such section.

6 **SEC. 104. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**
 7 **ICAL EXAMINATION.**

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

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

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

14 (3) by adding at the end the following new sub-
 15 paragraph:

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

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

21 “Initial Preventive Physical Examination

22 “(ww) The term ‘initial preventive physical examina-
 23 tion’ means physicians’ services consisting of a physical
 24 examination with the goal of health promotion and disease
 25 detection and includes a history and physical exam, a

1 health risk appraisal, and health risk counseling, and lab-
2 oratory tests or other items and services as determined
3 by the Secretary in consultation with the United States
4 Preventive Services Task Force.”.

5 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

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

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

10 (B) by inserting before the period at the
11 end the following: “, and (7) such deductible
12 shall not apply with respect to an initial preven-
13 tive physical examination (as defined in section
14 1861(w))”.

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

17 (A) in clause (N), by inserting “(or 100
18 percent in the case of an initial preventive phys-
19 ical examination, as defined in section
20 1861(w))” after “80 percent”; and

21 (B) in clause (O), by inserting “(or 100
22 percent in the case of an initial preventive phys-
23 ical examination, as defined in section
24 1861(w))” after “80 percent”.

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

4 (e) OTHER CONFORMING AMENDMENTS.—Section
5 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

6 (1) in paragraph (1)—

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

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

11 (C) by adding at the end the following new
12 subparagraph:

13 “(J) in the case of an initial preventive physical
14 examination (as defined in section 1861(w)), which
15 is performed not later than 6 months after the date
16 the individual's first coverage period begins under
17 part B;”; and

18 (2) in paragraph (7), by striking “or (H)” and
19 inserting “(H), or (J)”.

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

1 **Subtitle B—Medicare Coverage for**
 2 **Care Coordination and Assess-**
 3 **ment Services**

4 **SEC. 111. CARE COORDINATION AND ASSESSMENT SERV-**
 5 **ICES.**

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

9 “CARE COORDINATION AND ASSESSMENT SERVICES

10 “SEC. 1897. (a) PURPOSE.—

11 “(1) IN GENERAL.—The purpose of this section
 12 is to provide the appropriate level and mix of follow-
 13 up care to an individual with a chronic condition
 14 who qualifies as an eligible beneficiary (as defined in
 15 paragraph (2)).

16 “(2) ELIGIBLE BENEFICIARY DEFINED.—In
 17 this section, the term ‘eligible beneficiary’ means a
 18 beneficiary who—

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

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

23 “(b) ELECTION OF CARE COORDINATION AND AS-
 24 SESSMENT SERVICES.—

1 “(1) IN GENERAL.—On or after January 1,
2 2005, an eligible beneficiary may elect to receive
3 care coordination services in accordance with the
4 provisions of this section under which, in appro-
5 priate circumstances, the eligible beneficiary has
6 health care services covered under this title managed
7 and coordinated by a care coordinator who is quali-
8 fied under subsection (e) to furnish care coordina-
9 tion services under this section.

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

13 “(c) OUTREACH.—The Secretary shall provide for the
14 wide dissemination of information to beneficiaries and pro-
15 viders of services, physicians, practitioners, and suppliers
16 with respect to the availability of and requirements for
17 care coordination services under this section.

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

21 “(1) BASIC CARE COORDINATION AND ASSESS-
22 MENT SERVICES.—Except as otherwise provided in
23 this section, eligible beneficiaries who have made an
24 election under this section shall receive the following
25 services:

1 “(A)(i) An initial assessment of an individ-
2 ual’s medical condition, functional and cognitive
3 capacity, and environmental and psychosocial
4 needs.

5 “(ii) Annual assessments after the initial
6 assessment performed under clause (i), unless
7 the physician or care coordinator of the indi-
8 vidual determines that additional assessments
9 are required due to sentinel health events or
10 changes in the health status of the individual
11 that may require changes in the plan of care
12 developed for the individual.

13 “(B) The development of an initial plan of
14 care, and subsequent appropriate revisions to
15 that plan of care.

16 “(C) The management of, and referral for,
17 medical and other health services, including
18 multidisciplinary care conferences and coordina-
19 tion with other providers.

20 “(D) The monitoring and management of
21 medications.

22 “(E) Patient education and counseling
23 services.

24 “(F) Family caregiver education and coun-
25 seling services.

1 “(G) Self-management services, including
2 health education and risk appraisal to identify
3 behavioral risk factors through self-assessment.

4 “(H) Consultations by telephone with phy-
5 sicians and other appropriate health care pro-
6 fessionals, including 24-hour access to a care
7 coordinator.

8 “(I) Coordination with the principal care-
9 giver in the home.

10 “(J) The managing and facilitating of
11 transitions among health care professionals and
12 across settings of care, including the following:

13 “(i) The pursuit the treatment option
14 elected by the individual.

15 “(ii) The inclusion of any advance di-
16 rective executed by the individual in the
17 medical file of the individual.

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

20 “(L) Information about, and referral to,
21 community-based services, including patient and
22 family caregiver education and counseling about
23 such services, and facilitating access to such
24 services when elected.

1 “(M) Information about, and referral to,
2 hospice services and palliative care, including
3 patient and family caregiver education and
4 counseling about hospice services and palliative
5 care, and facilitating transition to hospice when
6 elected.

7 “(N) Such other medical and health care
8 services for which payment would not otherwise
9 be made under this title as the Secretary deter-
10 mines to be appropriate for effective care co-
11 ordination, including the additional items and
12 services as described in paragraph (2).

13 “(2) ADDITIONAL BENEFITS.—The Secretary
14 may specify additional benefits for which payment
15 would not otherwise be made under this title that
16 may be available to eligible beneficiaries who have
17 made an election under this section (subject to an
18 assessment by the care coordinator of an individual
19 beneficiary’s circumstances and need for such bene-
20 fits) in order to encourage the receipt of, or to im-
21 prove the effectiveness of, care coordination services.

22 “(e) CARE COORDINATORS.—

23 “(1) REQUIREMENT FOR CERTIFICATION.—

24 “(A) IN GENERAL.—In order to be quali-
25 fied to furnish care coordination and assess-

1 ment services under this section, an individual
2 or entity shall be a health care professional or
3 entity (which may include physicians, physician
4 group practices, or other health care profes-
5 sionals or entities the Secretary may find ap-
6 propriate) who has been certified for a period
7 (as provided in subparagraph (B)) by the Sec-
8 retary, or by an organization recognized by the
9 Secretary, as having met such criteria as the
10 Secretary may establish for the furnishing of
11 care coordination under this section (which may
12 include experience in the provision of care co-
13 ordination or primary care physician’s services).

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

17 “(i) A one-year period for each of the
18 first three years of participation under this
19 section.

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

21 “(2) ADDITIONAL REQUIREMENTS.—

22 “(A) SUBMISSION OF DATA.—A care coor-
23 dinator shall comply with such data collection
24 and reporting requirements as the Secretary de-

1 termines necessary to assess the effect of care
2 coordination on health outcomes.

3 “(B) PARTICIPATION IN QUALITY IM-
4 PROVEMENT PROGRAM.—A care coordinator
5 shall participate in the quality improvement
6 program under paragraph (3).

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

10 “(3) QUALITY IMPROVEMENT PROGRAM.—

11 “(A) IN GENERAL.—The Secretary shall
12 establish a chronic care quality assurance pro-
13 gram to monitor and improve clinical outcomes
14 for beneficiaries with chronic conditions.

15 “(B) ELEMENTS OF PROGRAM.—Under the
16 program, the Secretary shall—

17 “(i) establish standards to measure—

18 “(I) quality and performance of
19 the care of chronic conditions;

20 “(II) the continuity and coordi-
21 nation of care that eligible bene-
22 ficiaries under this section receive;
23 and

24 “(III) both underutilization and
25 overutilization of services;

1 “(ii) provide to care coordinators peri-
2 odic reports on their performance on such
3 measures; and

4 “(iii) make available information on
5 quality and outcomes measures to facilitate
6 beneficiary comparison and choice of care
7 coordination options (in such form and on
8 such quality and outcomes measures as the
9 Secretary determines to be appropriate).

10 “(C) REVIEW OF CLAIMS.—

11 “(i) IN GENERAL.—Subject to clause
12 (ii), under the program the Secretary shall
13 make available to care coordinators claims
14 data relating to a beneficiary for whom the
15 coordinator coordinates care under this
16 section for the coordinator’s review and
17 subsequent appropriate follow-up action.

18 “(ii) AUTHORIZATION.—Data may
19 only be provided to a care coordinator
20 under clause (i) if the eligible beneficiary
21 involved has given written authorization
22 for such information to be so provided.

23 “(4) LIMITATION ON NUMBER OF CARE COOR-
24 DINATORS.—Payment may only be made under this
25 section for care coordination services furnished dur-

1 ing a period to one care coordinator with respect to
2 an eligible beneficiary.

3 “(5) PAYMENT FOR SERVICES.—

4 “(A) IN GENERAL.—The Secretary shall
5 establish payment terms and conditions and
6 payment rates for basic care coordination and
7 assessment services described in subsection (d).

8 “(B) PAYMENT METHODOLOGY.—Payment
9 under this section shall be made in a manner
10 that bundles payment for all care coordination
11 and assessment services furnished during a pe-
12 riod, as specified by the Secretary.

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

16 “(f) DEFINITIONS.—In this section:

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

23 “(A) the individual has a level of disability
24 such that the individual is unable to perform
25 (without substantial assistance from another in-

1 dividual) for a period of at least 90 days due
2 to a loss of functional capacity—

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

4 or

5 “(ii) such number of instrumental ac-
6 tivities of daily living that is equivalent (as
7 determined by the Secretary) to the level
8 of disability described in clause (i); and

9 “(B) the individual has a level of disability
10 equivalent (as determined by the Secretary) to
11 the level of disability described in subparagraph
12 (A); or

13 “(C) the individual requires substantial su-
14 pervision to protect the individual from threats
15 to health and safety due to severe cognitive im-
16 pairment.

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

20 “(A) Eating.

21 “(B) Toileting.

22 “(C) Transferring.

23 “(D) Bathing.

24 “(E) Dressing.

25 “(F) Continence.

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

4 “(A) Medication management.

5 “(B) Meal preparation.

6 “(C) Shopping.

7 “(D) Housekeeping.

8 “(E) Laundry.

9 “(F) Money management.

10 “(G) Telephone use.

11 “(H) Transportation use.

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

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

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

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

19 “(5) BENEFICIARY.—The term ‘beneficiary’
20 means an individual entitled to benefits under part
21 A and enrolled under part B, including an individual
22 enrolled under the Medicare+Choice program under
23 part C.”.

24 (b) COVERAGE OF CARE COORDINATION AND AS-
25 SESSMENT SERVICES 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)) is amended—

3 (A) in the second sentence, by redesi-
4 gnating paragraphs (16) and (17) as clauses (i)
5 and (ii); and

6 (B) in the first sentence—

7 (i) by striking “and” at the end of
8 paragraph (14);

9 (ii) by striking the period at the end
10 of paragraph (15) and inserting “; and”;
11 and

12 (iii) by adding after paragraph (15)
13 the following new paragraph:

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

17 (2) CONFORMING AMENDMENTS.—Sections
18 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of
19 such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and
20 1396n(a)(1)(B)(ii)(I)) are each amended by striking
21 “paragraphs (16) and (17)” each place it appears
22 and inserting “clauses (i) and (ii) of the second sen-
23 tence”.

1 (3) PART B COINSURANCE AND DEDUCTIBLE
2 NOT APPLICABLE TO CARE COORDINATION AND AS-
3 SESSMENT SERVICES.—

4 (A) COINSURANCE.—Section 1833(a)(1) of
5 the Social Security Act (42 U.S.C. 1395l(a)(1))
6 is amended—

7 (i) by striking “and” at the end of
8 subparagraph (T); and

9 (ii) by inserting before the final semi-
10 colon “, and (V) with respect to care co-
11 ordination and assessment services de-
12 scribed in section 1861(s)(16) that are fur-
13 nished by, or coordinated through, a care
14 coordinator, the amounts paid shall be 100
15 percent of the payment amount established
16 under section 1897”.

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

19 (i) by striking “and” at the end of
20 paragraph (5); and

21 (ii) by inserting before the final period
22 “, and (7) such deductible shall not apply
23 with respect to care coordination and as-
24 sessment services (as described in section
25 1861(s)(16))”.

1 (C) ELIMINATION OF COINSURANCE IN
 2 OUTPATIENT HOSPITAL SETTINGS.—The third
 3 sentence of section 1866(a)(2)(A) of such Act
 4 (42 U.S.C. 1395cc(a)(2)(A)), as amended by
 5 section 101(b)(2), is further amended by insert-
 6 ing after “section 1833(p),” the following:
 7 “with respect to care coordination and assess-
 8 ment services (as described in section
 9 1861(s)(16)),”.

10 **SEC. 112. CARE COORDINATION AND ASSESSMENT SERV-**
 11 **ICES AND QUALITY IMPROVEMENT PROGRAM**
 12 **IN MEDICARE+CHOICE PLANS.**

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

18 **SEC. 113. IMPROVING CHRONIC CARE COORDINATION**
 19 **THROUGH INFORMATION TECHNOLOGY.**

20 (a) TECHNOLOGY IMPROVEMENT GRANTS.—

21 (1) IN GENERAL.—The Secretary of Health and
 22 Human Services (hereinafter in this section referred
 23 to as the “Secretary”) shall make grants to eligible
 24 entities to enable such entities to develop, imple-
 25 ment, or train personnel in the use of standardized

1 clinical information technology systems designed
2 to—

3 (A) improve the coordination and quality
4 of care furnished to medicare beneficiaries with
5 chronic conditions; and

6 (B) increase administrative efficiencies of
7 such entities.

8 (2) CARE COORDINATORS AS ELIGIBLE ENTI-
9 TIES.—In this section, an eligible entity is a care co-
10 ordinator who furnishes care coordination services to
11 medicare beneficiaries under section 1897 of the So-
12 cial Security Act.

13 (b) ELIGIBILITY.—To be eligible to receive a grant
14 under subsection (a), a care coordinator shall—

15 (1) prepare and submit to the Secretary an ap-
16 plication at such time, in such manner, and con-
17 taining such information as the Secretary may re-
18 quire, including a description of the clinical informa-
19 tion technology system that the care coordinator in-
20 tends to implement using amounts received under
21 the grant;

22 (2) provide assurances that are satisfactory to
23 the Secretary that such system, for which amounts
24 are to be expended under the grant, conforms to the
25 standards established by the Secretary under part C

1 of title XI of the Social Security Act, and such other
2 standards as the Secretary may specify; and

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

5 (A) evaluate the project for which the
6 grant is made; and

7 (B) ensure that funding provided under
8 the grant is expended for the purposes for
9 which it is made.

10 (c) MATCHING REQUIREMENT.—The Secretary may
11 not make a grant to a care coordinator under subsection
12 (a) unless that care coordinator agrees that, with respect
13 to the costs to be incurred by the care coordinator in car-
14 rying out the activities for which the grant is being award-
15 ed, the care coordinator will make available (directly or
16 through donations from public or private entities) non-
17 Federal contributions toward such costs in an amount
18 equal to \$1 for each \$1 of Federal funds provided under
19 the grant.

20 (d) REPORTS TO CONGRESS.—

21 (1) INITIAL REPORT.—Not later than 18
22 months after the first grant has been made under
23 this section, the Secretary shall submit an initial re-
24 port to Congress containing the information referred

1 to in paragraph (3) as well as any recommendations
2 with respect to grants under this section.

3 (2) FINAL REPORT.—Not later than 6 months
4 after the last grant has been awarded (as deter-
5 mined by the Secretary) under this section, the Sec-
6 retary shall submit a final report to Congress con-
7 taining the information referred to in paragraph (2)
8 as well as any recommendations with respect to
9 grants under this section.

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

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

14 (B) An evaluation of—

15 (i) improvements in the coordination
16 and quality of care furnished to bene-
17 ficiaries with chronic conditions; and

18 (ii) increases in administrative effi-
19 ciencies of care coordinators.

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

1 **Subtitle C—Additional Provisions**

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

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

10 (1) regulations, policies, procedures, and in-
11 structions of the Centers for Medicare & Medicaid
12 Services for making those determinations; and

13 (2) policies, procedures, local medical review
14 policies, manual instructions, interpretative rules,
15 statements of policy, and guidelines of general appli-
16 cability of fiscal intermediaries (under section 1816
17 of the Social Security Act (42 U.S.C. 1395h)) and
18 carriers under section 1842 of such Act (42 U.S.C.
19 1395u) for making those determinations.

20 (b) MODIFICATION.—Insofar as the Secretary deter-
21 mines that the Centers for Medicare & Medicaid Services,
22 a fiscal intermediary, or a carrier has misapplied such
23 standard by requiring that the item or service improve the
24 condition of the patient with respect to such illness or in-
25 jury, the Secretary shall take such corrective measures as

1 are appropriate to ensure the Centers, intermediary, or
 2 carrier (as the case may be) applies the proper standard
 3 for making such determinations.

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

7 (1) a detailed statement of the findings and
 8 conclusions of the review conducted under subsection
 9 (a);

10 (2) a detailed statement of the modifications
 11 made under subsection (b); and

12 (3) recommendations to avoid misapplication of
 13 the standard in the future.

14 **TITLE II—INSTITUTE OF MEDI-**
 15 **CINE STUDY ON EFFECTIVE**
 16 **CHRONIC CONDITION CARE**

17 **SEC. 201. INSTITUTE OF MEDICINE MEDICARE CHRONIC**
 18 **CONDITION CARE IMPROVEMENT STUDY AND**
 19 **REPORT.**

20 (a) STUDY.—

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

24 (A) conduct a comprehensive study of the
 25 medicare program to identify—

1 (i) factors that facilitate provision of
2 effective care (including, where appro-
3 priate, hospice care) for medicare bene-
4 ficiaries with chronic conditions; and

5 (ii) factors that impede provision of
6 such care for such beneficiaries,

7 including the issues studied under paragraph
8 (2); and

9 (B) submit the report described in sub-
10 section (b).

11 (2) ISSUES STUDIED.—The study required
12 under paragraph (1) shall—

13 (A) identify inconsistent clinical, financial,
14 or administrative requirements across provider
15 and supplier settings or professional services
16 with respect to medicare beneficiaries; and

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

19 (i) promote costshifting across pro-
20 viders and suppliers;

21 (ii) impede provision of effective,
22 seamless transitions across health care set-
23 tings, such as between hospitals, skilled
24 nursing facilities, home health services,
25 hospice care, and care in the home;

1 (iii) impose unnecessary burdens on
2 such beneficiaries and their family care-
3 givers;

4 (iv) impede the establishment of ad-
5 ministrative information systems to track
6 health status, utilization, cost, and quality
7 data across providers and suppliers and
8 provider settings;

9 (v) impede the establishment of clin-
10 ical information systems that support con-
11 tinuity of care across settings and over
12 time; or

13 (vi) impede the alignment of financial
14 incentives among the medicare program,
15 the medicaid program, and group health
16 plans and providers and suppliers that fur-
17 nish services to the same beneficiary.

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

23 (1) a detailed statement of the findings and
24 conclusions of the study conducted under subsection
25 (a); and

- 1 (2) recommendations to improve provision of ef-
- 2 fective care for medicare beneficiaries with chronic
- 3 conditions.

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