H.R.1

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
(Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE

(a) IN GENERAL- Title XVIII is amended by inserting after section 1806 the following new section:

CHRONIC CARE IMPROVEMENT

`SEC. 1807. (a) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS-

`(1) IN GENERAL- The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions.

`(2) DEFINITIONS- For purposes of this section:

`(A) CHRONIC CARE IMPROVEMENT PROGRAM- The term `chronic care improvement program' means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

`(B) CHRONIC CARE IMPROVEMENT ORGANIZATION- The term `chronic care improvement organization' means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

`(C) CARE MANAGEMENT PLAN- The term `care management plan' means a plan established under subsection (d) for a participant in a chronic care improvement program.

`(D) THRESHOLD CONDITION- The term `threshold condition' means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other

diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

`(E) TARGETED BENEFICIARY- The term `targeted beneficiary' means, with respect to a chronic care improvement program, an individual who--

`(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

`(ii) has one or more threshold conditions covered under such program; and

`(iii) has been identified under subsection (d)(1) as a potential participant in such program.

`(3) CONSTRUCTION- Nothing in this section shall be construed as--

`(A) expanding the amount, duration, or scope of benefits under this title;

`(B) providing an entitlement to participate in a chronic care improvement program under this section;

`(C) providing for any hearing or appeal rights under section 1869, 1878, or otherwise, with respect to a chronic care improvement program under this section; or

`(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1861(d)).

`(b) DEVELOPMENTAL PHASE (PHASE I)-

`(1) IN GENERAL- In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after the date of the enactment of this section.

`(2) AGREEMENT PERIOD- The period of an agreement under this subsection shall be for 3 years.

`(3) MINIMUM PARTICIPATION-

`(A) IN GENERAL- The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

`(B) MEDICARE BENEFICIARY DEFINED- In this paragraph, the term `medicare beneficiary' means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

`(4) SITE SELECTION- In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside

among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

`(5) INDEPENDENT EVALUATIONS OF PHASE I PROGRAMS- The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

`(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

`(B) Beneficiary and provider satisfaction.

`(C) Health outcomes.

`(D) Financial outcomes, including any cost savings to the program under this title.

`(c) EXPANDED IMPLEMENTATION PHASE (PHASE II)-

`(1) IN GENERAL- With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

`(2) CONDITIONS FOR EXPANSION OF PROGRAMS- The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to--

`(A) improve the clinical quality of care;

`(B) improve beneficiary satisfaction; and

`(C) achieve targets for savings to the program under this title specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

`(3) INDEPENDENT EVALUATIONS OF PHASE II PROGRAMS- The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

`(d) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS-

`(1) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS- The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

`(2) INITIAL CONTACT BY SECRETARY- The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

`(A) A description of the advantages to the beneficiary in participating in a program.

`(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

`(C) Notification that participation in a program is voluntary.

`(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

`(3) VOLUNTARY PARTICIPATION- A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

`(e) CHRONIC CARE IMPROVEMENT PROGRAMS-

`(1) IN GENERAL- Each chronic care improvement program shall--

`(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

`(B) provide each targeted beneficiary participating in the program with such plan; and

`(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

`(2) ELEMENTS OF CARE MANAGEMENT PLANS- A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

`(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

`(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

`(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

`(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

`(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

`(3) CONDUCT OF PROGRAMS- In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall--

`(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

`(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

`(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

`(4) ADDITIONAL RESPONSIBILITIES-

`(A) OUTCOMES REPORT- Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

`(B) ADDITIONAL REQUIREMENTS- Each such organization and program shall comply with such additional requirements as the Secretary may specify.

`(5) ACCREDITATION- The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

`(f) TERMS OF AGREEMENTS-

`(1) TERMS AND CONDITIONS-

`(A) IN GENERAL- An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

`(B) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS- The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless--

`(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

`(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available

reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

`(2) MANNER OF PAYMENT- Subject to paragraph (3)(B), the payment under an agreement under--

`(A) subsection (b) shall be computed on a per-member per-month basis; or

`(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

`(3) APPLICATION OF PERFORMANCE STANDARDS-

`(A) SPECIFICATION OF PERFORMANCE STANDARDS- Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

`(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE-

`(i) IN GENERAL- Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

`(ii) FINANCIAL RISK FOR PERFORMANCE- In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement.

`(4) BUDGET NEUTRAL PAYMENT CONDITION- Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

`(g) FUNDING- (1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

`(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.'.

(b) REPORTS- The Secretary shall submit to Congress reports on the operation of section 1807 of the Social Security Act, as added by subsection (a), as follows:

(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on--

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the programs; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.