

109TH CONGRESS  
1ST SESSION

# S. 40

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with access to geriatric assessments and chronic care management, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JANUARY 24, 2005

Mrs. LINCOLN (for herself, Mr. BINGAMAN, Mrs. MURRAY, Ms. LANDRIEU, Mrs. BOXER, Mr. SARBANES, and Ms. COLLINS) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with access to geriatric assessments and chronic care management, 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 “Geriatric and Chronic Care Management Act of 2005”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. Medicare coverage of geriatric assessments.

Sec. 4. Medicare coverage of chronic care management services.

Sec. 5. Study and report on best practices for medicare chronic care management.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) We must redesign the medicare system to  
4 provide high-quality, cost-effective care to a growing  
5 population: elderly individuals with multiple chronic  
6 conditions.

7 (2) According to the Congressional Budget Of-  
8 fice, 50 percent of medicare costs can be attributed  
9 to 5 percent of medicare's most costly beneficiaries.

10 (3) Currently, 82 percent of the medicare popu-  
11 lation has at least 1 chronic condition, and  $\frac{2}{3}$  have  
12 more than 1 chronic condition. The 20 percent of  
13 beneficiaries with 5 or more chronic conditions ac-  
14 count for  $\frac{2}{3}$  of all medicare spending. In addition,  
15 the large Baby Boomer generation is moving toward  
16 retirement and medicare eligibility.

17 (4) In general, the prevalence of chronic condi-  
18 tions increases with age: 74 percent of the 65- to  
19 69-year-old group have at least 1 chronic condition,  
20 while 86 percent of the 85 years and older group  
21 have at least 1 chronic condition. Similarly, just 14  
22 percent of the 65- to 69-year-olds have 5 or more

1 chronic conditions, but 28 percent of the 85 years  
2 and older group have 5 or more chronic conditions.

3 (5) There is a strong pattern of increasing utili-  
4 zation as the number of conditions increase. Fifty-  
5 five percent of medicare beneficiaries with 5 or more  
6 conditions experienced an inpatient hospital stay  
7 compared to 5 percent for those with 1 condition or  
8 9 percent for those with 2 conditions.

9 (6) In terms of physician visits, the average  
10 medicare beneficiary has over 15 physician visits an-  
11 nually and sees 6 different physicians annually.

12 (7) There is almost a 4-fold increase in visits by  
13 people with 5 chronic conditions compared to visits  
14 by people with 1 chronic condition. The number of  
15 specific physicians seen increases almost 2½ times  
16 for people with 5 or more chronic conditions relative  
17 to those with just 1 chronic condition.

18 (8) When Alzheimer's disease and dementia are  
19 present along with 1 or more other chronic condi-  
20 tions, utilization also increases. For example, in  
21 2000, total average per person medicare expendi-  
22 tures for those with congestive heart failure and Alz-  
23 heimer's or dementia were 47 percent higher than  
24 for those with congestive heart failure and no de-  
25 mentia.

1           (9) Based on numerous studies in the United  
2 States and internationally, we know that the delivery  
3 of higher quality health care, increased efficiency  
4 and cost-effectiveness are the result of systems in  
5 which patients are linked with a physician or other  
6 qualified health professional who coordinates their  
7 care.

8           (10) The current medicare program penalizes  
9 physicians for integrating and coordinating health  
10 care because these services are not explicitly recog-  
11 nized and distinctly paid for. Instead, physicians are  
12 incentivized to provide episodic care and to generate  
13 more individual patient visits to the doctor's office  
14 and hospital for separately reimbursed tests and  
15 procedures.

16           (11) The chronic care model established by this  
17 Act includes several elements that are effective in  
18 managing chronic disease—

19                   (A) linkages with community resources;

20                   (B) health care system changes that re-  
21 ward quality chronic care;

22                   (C) support for patient self-management of  
23 chronic disease;

24                   (D) practice redesign;

1 (E) evidence-based clinical practice guide-  
 2 lines; and

3 (F) clinical information systems, such as  
 4 electronic medical records and continuity of  
 5 care records.

6 (12) We must realign the financial incentives  
 7 within medicare as part of a comprehensive system  
 8 change. Medicare should be restructured to reim-  
 9 burse physicians and other qualified health profes-  
 10 sionals for the cost of coordinating care.

11 **SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESS-**  
 12 **MENTS.**

13 (a) PART B COVERAGE OF GERIATRIC ASSESS-  
 14 MENTS.—

15 (1) IN GENERAL.—Section 1861(s)(2) of the  
 16 Social Security Act (42 U.S.C. 1395x(s)(2)) is  
 17 amended—

18 (A) in subparagraph (Y), by striking  
 19 “and” after the semicolon at the end;

20 (B) in subparagraph (Z), by adding “and”  
 21 after the semicolon at the end; and

22 (C) by adding at the end the following new  
 23 subparagraph:

24 “(AA) geriatric assessments (as defined in sub-  
 25 section (bbb)(1));”.

1           (2) CONFORMING AMENDMENTS.—(A) Section  
2           1862(a)(7) of the Social Security Act (42 U.S.C.  
3           1395y(a)(7)) is amended by striking “or (K)” and  
4           inserting “(K), or (AA)”.

5           (B) Clauses (i) and (ii) of section  
6           1861(s)(2)(K) of the Social Security Act (42 U.S.C.  
7           1395x(s)(2)(K)) are each amended by striking “sub-  
8           section (ww)(1)” and inserting “subsections (ww)(1)  
9           and (bbb)(1)”.

10          (b) GERIATRIC ASSESSMENTS DEFINED.—Section  
11          1861 of the Social Security Act (42 U.S.C. 1395x) is  
12          amended by adding at the end the following new sub-  
13          section:

14                 “Geriatric Assessment; Eligible Individual  
15                 “(bbb)(1) The term ‘geriatric assessment’ means—  
16                 “(A) an initial assessment of an eligible individ-  
17                 ual’s medical condition, functional and cognitive ca-  
18                 pacity, primary caregiver needs, and environmental  
19                 and psychosocial needs that is conducted by a physi-  
20                 cian or an entity that meets such conditions as the  
21                 Secretary may specify (which may include physi-  
22                 cians, physician group practices, or other health care  
23                 professionals or entities the Secretary may find ap-  
24                 propriate) working in collaboration with a physician;  
25                 and

1           “(B) subsequent assessments, which may not be  
2           conducted more frequently than annually, unless a  
3           physician or chronic care manager of the eligible in-  
4           dividual determines that such assessments are re-  
5           quired due to sentinel health events or changes in  
6           the health status of the individual that may require  
7           changes in plans of care developed for the individual.

8           “(2)(A) For purposes of this subsection, the term ‘eli-  
9           gible individual’ means an individual who has—

10           “(i) at least 5 chronic conditions and an inabil-  
11           ity to manage care (as defined by the Secretary); or

12           “(ii) a mental or cognitive impairment, includ-  
13           ing dementia, and at least 1 other chronic condition.

14           “(B) For purposes of this paragraph, the term  
15           ‘chronic condition’ means an illness, functional limitation,  
16           or cognitive impairment that is expected to last at least  
17           1 year, limits the activities of an individual, and requires  
18           ongoing care.”.

19           (c) PAYMENT AND ELIMINATION OF COST-SHAR-  
20           ING.—

21           (1) PAYMENT AND ELIMINATION OF COINSUR-  
22           ANCE.—Section 1833(a)(1) of the Social Security  
23           Act (42 U.S.C. 1395l(a)(1)) is amended—

24           (A) in subparagraph (N), by inserting  
25           “other than geriatric assessments (as defined in

1 section 1861(bbb)(1))” after “(as defined in  
2 section 1848(j)(3))”;

3 (B) by striking “and” before “(V)”;

4 (C) by inserting before the semicolon at  
5 the end the following: “, and (W) with respect  
6 to geriatric assessments (as defined in section  
7 1861(bbb)(1)), the amount paid shall be 100  
8 percent of the lesser of the actual charge for  
9 the services or the amount determined under  
10 the payment basis determined under section  
11 1848”.

12 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-  
13 ULE.—Section 1848(j)(3) of the Social Security Act  
14 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting  
15 “(2)(AA),” after “(2)(W),”.

16 (3) ELIMINATION OF COINSURANCE IN OUT-  
17 PATIENT HOSPITAL SETTINGS.—

18 (A) EXCLUSION FROM OPD FEE SCHED-  
19 ULE.—Section 1833(t)(1)(B)(iv) of the Social  
20 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is  
21 amended by striking “and diagnostic mammog-  
22 raphy” and inserting “, diagnostic mammog-  
23 raphy, or geriatric assessments (as defined in  
24 section 1861(bbb)(1))”.



1 (B) CONFORMING AMENDMENTS.—Section  
 2 1833(a)(2) of the Social Security Act (42  
 3 U.S.C. 1395l(a)(2)) is amended—

4 (i) in subparagraph (F), by striking  
 5 “and” after the semicolon at the end;

6 (ii) in subparagraph (G)(ii), by strik-  
 7 ing the comma at the end and inserting “;  
 8 and”; and

9 (iii) by inserting after subparagraph  
 10 (G)(ii) the following new subparagraph:

11 “(H) with respect to geriatric assessments  
 12 (as defined in section 1861(bbb)(1)) furnished  
 13 by an outpatient department of a hospital, the  
 14 amount determined under paragraph (1)(W),”.

15 (4) ELIMINATION OF DEDUCTIBLE.—The first  
 16 sentence of section 1833(b) of the Social Security  
 17 Act (42 U.S.C. 1395l(b)) is amended—

18 (A) by striking “and” before “(6)”; and

19 (B) by inserting before the period the fol-  
 20 lowing: “, and (7) such deductible shall not  
 21 apply with respect to geriatric assessments (as  
 22 defined in section 1861(bbb)(1))”.

23 (d) FREQUENCY LIMITATION.—Section 1862(a)(1) of  
 24 the Social Security Act (42 U.S.C. 1395y(a)(1)) is amend-  
 25 ed—

1           (1) by striking “and” at the end of subpara-  
2 graph (L);

3           (2) by striking the semicolon at the end of sub-  
4 paragraph (M) and inserting “, and”; and

5           (3) by adding at the end the following new sub-  
6 paragraph:

7           “(N) in the case of geriatric assessments (as  
8 defined in section 1861(bbb)(1)), which are per-  
9 formed more frequently than is covered under such  
10 section;”.

11       (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-  
12 RALS.—Section 1877(b) of the Social Security Act (42  
13 U.S.C. 1395nn(b)) is amended by adding at the end the  
14 following new paragraph:

15           “(6) GERIATRIC ASSESSMENTS.—In the case of  
16 a designated health service, if the designated health  
17 service is a geriatric assessment (as defined in sec-  
18 tion 1861(bbb)(1)) and furnished by a physician.”.

19       (f) RULEMAKING.—The Secretary of Health and  
20 Human Services shall define such terms and establish  
21 such procedures as the Secretary determines necessary to  
22 implement the provisions of this section.

23       (g) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to assessments and chronic care

1 management services furnished on or after January 1,  
2 2006.

3 **SEC. 4. MEDICARE COVERAGE OF CHRONIC CARE MANAGE-**  
4 **MENT SERVICES.**

5 (a) PART B COVERAGE OF CHRONIC CARE MANAGE-  
6 MENT SERVICES.—

7 (1) IN GENERAL.—Section 1861(s)(2) of the  
8 Social Security Act (42 U.S.C. 1395x(s)(2)), as  
9 amended by section 3(a)(1), is amended—

10 (A) in subparagraph (Z), by striking  
11 “and” after the semicolon at the end;

12 (B) in subparagraph (AA), by adding  
13 “and” after the semicolon at the end; and

14 (C) by adding at the end the following new  
15 subparagraph:

16 “(BB) chronic care management services (as  
17 defined in subsection (ccc));”.

18 (2) CONFORMING AMENDMENTS.—

19 (A) Section 1862(a)(7) of the Social Secu-  
20 rity Act (42 U.S.C. 1395y(a)(7)), as amended  
21 section 3(a)(2)(A), is amended by striking “or  
22 (AA)” and inserting “(AA), or (BB)”.

23 (B) Clauses (i) and (ii) of section  
24 1861(s)(2)(K) of the Social Security Act (42  
25 U.S.C. 1395x(s)(2)(K)), as amended by section

1           3(a)(2)(B), are each amended by striking “sub-  
2           sections (ww)(1) and (bbb)” and inserting “sub-  
3           sections (ww)(1), (bbb), and (ccc)”.

4           (b) SERVICES DESCRIBED.—Section 1861 of the So-  
5           cial Security Act (42 U.S.C. 1395x), as amended by sec-  
6           tion 3(b), is amended by adding at the end the following  
7           new subsection:

8           “Chronic Care Management Services; Chronic Care  
9                           Manager; Eligible Individual

10          “(ccc)(1) The term ‘chronic care management serv-  
11          ices’ means services that are furnished to an eligible indi-  
12          vidual (as defined in paragraph (3)) by a chronic care  
13          manager (as defined in paragraph (2)) under a plan of  
14          care prescribed by such chronic care manager for the pur-  
15          pose of chronic care management, which may include any  
16          of the following services:

17               “(A) The development of an initial plan of care,  
18               and subsequent appropriate revisions to that plan of  
19               care.

20               “(B) The management of, and referral for,  
21               medical and other health services, including inter-  
22               disciplinary care conferences and management with  
23               other providers.

24               “(C) The monitoring and management of medi-  
25               cations.

1           “(D) Patient education and counseling services.

2           “(E) Family caregiver education and counseling  
3 services.

4           “(F) Self-management services, including  
5 health education and risk appraisal to identify be-  
6 havioral risk factors through self-assessment.

7           “(G) Providing access for consultations by tele-  
8 phone with physicians and other appropriate health  
9 care professionals, including 24-hour availability of  
10 such professionals for emergency consultations.

11           “(H) Management with the principal nonprofes-  
12 sional caregiver in the home.

13           “(I) Managing and facilitating transitions  
14 among health care professionals and across settings  
15 of care, including the following:

16               “(i) Pursuing the treatment option elected  
17 by the individual.

18               “(ii) Including any advance directive exe-  
19 cuted by the individual in the medical file of the  
20 individual.

21           “(J) Information about, and referral to, hospice  
22 services, including patient and family caregiver edu-  
23 cation and counseling about hospice, and facilitating  
24 transition to hospice when elected.

1           “(K) Information about, referral to, and man-  
2           agement with, community services.

3           “(L) Such additional services for which pay-  
4           ment would not otherwise be made under this title  
5           that the Secretary may specify that encourage the  
6           receipt of, or to improve the effectiveness of, the  
7           services described in the preceding subparagraphs.

8           “(2)(A) For purposes of this subsection, the term  
9           ‘chronic care manager’ means an individual or entity  
10          that—

11           “(i) is—

12                   “(I) a physician (as defined in subsection  
13                   (r)(1)); or

14                   “(II) a practitioner described in section  
15                   1842(b)(18)(C) or an entity that meets such  
16                   conditions as the Secretary may specify (which  
17                   may include physicians, physician group prac-  
18                   tices, or other health care professionals or enti-  
19                   ties the Secretary may find appropriate) work-  
20                   ing in collaboration with a physician;

21           “(ii) has entered into a chronic care manage-  
22           ment agreement with the Secretary; and

23           “(iii) meets such other criteria as the Secretary  
24           may establish (which may include experience in the

1 provision of chronic care management or primary  
2 care physicians' services).

3 “(B) For purposes of subparagraph (A)(ii), each  
4 chronic care management agreement shall—

5 “(i) be entered into for a period of 1 year and  
6 may be renewed if the Secretary is satisfied that the  
7 chronic care manager continues to meet the condi-  
8 tions of participation specified in subparagraph (A);

9 “(ii) ensure that the chronic care manager will  
10 submit reports to the Secretary on the functional  
11 and medical status of eligible individuals who receive  
12 chronic care management services, expenditures re-  
13 lating to such services, and health outcomes relating  
14 to such services, except that the Secretary may not  
15 require a chronic care manager to submit more than  
16 one such report during a year; and

17 “(iii) contain such other terms and conditions  
18 as the Secretary may require.

19 “(3) For purposes of this subsection, the term ‘eligi-  
20 ble individual’ means an eligible individual (as defined in  
21 subsection (bbb)(2)) who has undergone a geriatric assess-  
22 ment (as defined in subsection (bbb)(1)) and who a physi-  
23 cian has determined would benefit from chronic care man-  
24 agement.”.

1 (c) PAYMENT AND ELIMINATION OF COST-SHAR-  
2 ING.—

3 (1) PAYMENT AND ELIMINATION OF COINSUR-  
4 ANCE.—Section 1833(a)(1) of the Social Security  
5 Act (42 U.S.C. 1395l(a)(1)), as amended by section  
6 3(c)(1), is amended—

7 (A) in subparagraph (N), by inserting “or  
8 chronic care management services (as defined in  
9 section 1861(ccc))” after “other than geriatric  
10 assessments (as defined in section  
11 1861(bbb)(1))”;

12 (B) by striking “and” before “(W)”;

13 (C) by inserting before the semicolon at  
14 the end the following: “, and (X) with respect  
15 to chronic care management services (as de-  
16 fined in section 1861(ccc)), the amount paid  
17 shall be 100 percent of the amount determined  
18 under section 1834(n)”.

19 (2) PAYMENT.—Section 1834 of the Social Se-  
20 curity Act (42 U.S.C. 1395m) is amended by adding  
21 at the end the following new subsection:

22 “(n) PAYMENT FOR CHRONIC CARE MANAGEMENT  
23 SERVICES.—

24 “(1) IN GENERAL.—The Secretary shall pay for  
25 chronic care management services (as defined in sec-



1 tion 1861(ccc)(1)) furnished to an eligible individual  
2 (as defined in section 1861(ccc)(3)) by a chronic  
3 care manager (as defined in section 1861(ccc)(2))—

4 “(A) separately from geriatric assessments  
5 (as defined in section 1861(bbb)(1)) and other  
6 services for which payment is made under this  
7 title; and

8 “(B) based on the methodology selected by  
9 the chronic care manager (as so defined) from  
10 among the methodologies developed and imple-  
11 mented by the Secretary under paragraph (2).

12 “(2) DEVELOPMENT AND IMPLEMENTATION OF  
13 PAYMENT METHODOLOGIES.—The Secretary, in con-  
14 sultation with national membership associations rep-  
15 resenting physicians, qualified health professionals,  
16 and patients, shall develop and implement payment  
17 methodologies applicable with respect to chronic care  
18 management services (as defined in section  
19 1861(ccc)(1)) as follows:

20 “(A) UNADJUSTED MONTHLY CAPITATED  
21 PAYMENT AMOUNT.—A per patient per month  
22 chronic care management fee separate from  
23 evaluation and management services for which  
24 payment is made under the physician fee sched-  
25 ule under section 1848 that does not take into

1 account the severity of the eligible individual's  
2 condition.

3 “(B) ADJUSTED MONTHLY CAPITATED  
4 PAYMENT AMOUNT.—A per patient per month  
5 chronic care management fee separate from  
6 evaluation and management services for which  
7 payment is made under the physician fee sched-  
8 ular under section 1848 that provides for an ad-  
9 justment to the payment amount based on the  
10 severity of the eligible individual's condition.

11 “(C) UNADJUSTED FEE SCHEDULE  
12 AMOUNT.—A chronic care management fee for  
13 care coordination that includes payment for re-  
14 lated evaluation and management services for  
15 which payment would otherwise be made under  
16 the physician fee schedule under section 1848  
17 that does not take into account the severity of  
18 the eligible individual's condition.

19 “(D) ADJUSTED FEE SCHEDULE  
20 AMOUNT.—A chronic care management fee for  
21 care coordination that includes payment for re-  
22 lated evaluation and management services for  
23 which payment would otherwise be made under  
24 the physician fee schedule under section 1848  
25 that provides for an adjustment to the payment

1 amount based on the severity of the eligible in-  
 2 dividual’s condition.

3 “(E) OTHER PAYMENT METHODOLO-  
 4 GIES.—Any other payment methodology that  
 5 the Secretary determines effective in creating  
 6 incentives for physicians and other chronic care  
 7 managers to make practice-based improvements  
 8 to improve the quality and cost-effectiveness of  
 9 care provided to eligible individuals.”.

10 (3) ELIMINATION OF COINSURANCE IN OUT-  
 11 PATIENT HOSPITAL SETTINGS.—

12 (A) EXCLUSION FROM OPD FEE SCHED-  
 13 ULE.—Section 1833(t)(1)(B)(iv) of the Social  
 14 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as  
 15 amended by section 3(c)(3)(A), is amended by  
 16 striking “or geriatric assessments (as defined in  
 17 section 1861(bbb)(1))” and inserting “geriatric  
 18 assessments (as defined in section  
 19 1861(bbb)(1)), or chronic care management  
 20 services (as defined in section 1861(ccc)(1))”.

21 (B) CONFORMING AMENDMENTS.—Section  
 22 1833(a)(2) of the Social Security Act (42  
 23 U.S.C. 1395l(a)(2)) is amended—

24 (i) in subparagraph (G)(ii), by strik-  
 25 ing “and” after the semicolon at the end;

1 (ii) in subparagraph (H), by striking  
2 the comma at the end and inserting “;  
3 and”; and

4 (iii) by inserting after subparagraph  
5 (H) the following new subparagraph:

6 “(I) with respect to chronic care manage-  
7 ment services (as defined in section  
8 1861(ccc)(1)) furnished by an outpatient de-  
9 partment of a hospital, the amount determined  
10 under section 1834(n),”.

11 (4) ELIMINATION OF DEDUCTIBLE.—Section  
12 1833(b)(7) of the Social Security Act (42 U.S.C.  
13 1395l(b)(7)), as added by section 3(e)(4), is amend-  
14 ed by inserting “or chronic care management serv-  
15 ices (as defined in section 1861(ccc)(1))” after  
16 “geriatric assessments (as defined in section  
17 1861(bbb)(1))”.

18 (d) APPLICATION OF LIMITS ON BILLING.—Section  
19 1842(b)(18)(C) of the Social Security Act (42 U.S.C.  
20 1395u(b)(18)(C)) is amended by adding at the end the  
21 following new clause:

22 “(vii) A chronic care manager (as defined in  
23 section 1861(ccc)(2)) that is not a physician.”.

24 (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-  
25 RALS.—Section 1877(b)(6) of the Social Security Act (42

1 U.S.C. 1395nn(b)(6)), as amended by section 3(e), is  
 2 amended to read as follows:

3 “(6) GERIATRIC ASSESSMENTS AND CHRONIC  
 4 CARE MANAGEMENT SERVICES.—In the case of a  
 5 designated health service, if the designated health  
 6 service is—

7 “(A) a geriatric assessment or a chronic  
 8 care management service (as defined in sub-  
 9 sections (bbb)(1) or (ccc)(1) of section 1861,  
 10 respectively); and

11 “(B) provided by a physician or a chronic  
 12 care manager (as defined in section  
 13 1861(ccc)(2)).”.

14 (f) RULEMAKING.—The Secretary of Health and  
 15 Human Services shall define such terms and establish  
 16 such procedures as the Secretary determines necessary to  
 17 implement the provisions of this section.

18 (g) EFFECTIVE DATE.—The amendments made by  
 19 this section shall apply to assessments and chronic care  
 20 management services furnished on or after January 1,  
 21 2006.

22 **SEC. 5. STUDY AND REPORT ON BEST PRACTICES FOR**  
 23 **MEDICARE CHRONIC CARE MANAGEMENT.**

24 (a) STUDY.—The Secretary of Health and Human  
 25 Services, in consultation with the Medicare Payment Advi-

1 sory Commission, shall conduct a thorough study of the  
2 following issues:

3 (1) The effectiveness of the different payment  
4 methodologies applicable with respect to chronic care  
5 management services developed and implemented  
6 under section 1834(n)(2) of the Social Security Act  
7 (as added by section 4(c)(2)).

8 (2) The effectiveness of pay-for-performance  
9 programs to serve medicare beneficiaries with mul-  
10 tiple chronic conditions, including dementia.

11 (3) Process measures and outcomes for medi-  
12 care beneficiaries with multiple chronic illnesses, in-  
13 cluding dementia.

14 (4) The cost-effectiveness and quality associated  
15 with chronic care management under the medicare  
16 program.

17 (5) The feasibility of broadening and incor-  
18 porating the findings of the Assessing Care of Vul-  
19 nerable Elders (ACOVE) study into the medicare  
20 program.

21 (b) REPORT.—Not later than the date that is 1 year  
22 after the date of enactment of this Act, the Secretary of  
23 Health and Human Services shall submit to Congress a  
24 report on the study conducted under subsection (a) that  
25 contains—

1           (1) recommendations on the best practices for  
2 chronic care management of the conditions of medi-  
3 care beneficiaries with multiple chronic conditions,  
4 including dementia; and

5           (2) such other recommendations for legislation  
6 or administrative action as the Secretary determines  
7 appropriate.

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