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107TH CONGRESS
1ST SESSION

S. 775

To amend title XVIII of the Social Security Act to permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the medicare program.

IN THE SENATE OF THE UNITED STATES

APRIL 25, 2001

Mrs. LINCOLN (for herself and Mr. REID) 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 permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Geriatric Care Act of 2001".

SEC. 2. DISREGARD OF CERTAIN GERIATRIC RESIDENTS AGAINST GRADUATE MEDICAL EDUCATION LIMITATIONS.

(a) DIRECT GME.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)) is amended by adding at the end the following new clause:

''(iii) INCREASE IN LIMITATION FOR GERIATRIC FELLOWSHIPS.—For cost reporting periods beginning on or after the date that is 6 months after the date of enactment of the Geriatric Care Act of 2001, in applying the limitations regarding the total number of full-time equivalent residents in the field of allopathic or osteopathic medicine under clause (i) for a hospital, the Secretary shall not take into account a maximum of 3 residents enrolled in a fellowship in geriatric medicine within an approved medical residency training program to the extent that the hospital increases the number of geriatric residents above the number of such residents for the hospital's most recent cost reporting period ending before the date that is 6 months after the date of enactment of such Act.''.

(b) INDIRECT GME.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(ix) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

SEC. 3. MEDICARE COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.

(a) PART B COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 105(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' after the semicolon at the end; and

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

''(W) care coordination and assessment services (as defined in subsection (ww)).''.

(b) CARE COORDINATION AND ASSESSMENT SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 105(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by adding at the end the following new subsection:

''Care Coordination and Assessment Services; Qualified Frail Elderly or At-Risk Individual; Care Coordinator

''(ww)(1) The term 'care coordination and assessment services' means services that are furnished to a qualified frail elderly or at-risk individual (as defined in paragraph (2)) by a care coordinator (as defined in paragraph (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

''(A) An initial and periodic health screening and assessment.

''(B) The management of, and referral for, medical and other health services, including multidisciplinary care conferences and coordination with other providers.

''(C) The monitoring and management of medications, particularly with respect to the management

on behalf of a qualified frail elderly or at-risk individual of multiple medications prescribed for that individual.

''(D) Patient and family caregiver education and counseling services.

''(E) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(F) Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergency consultations.

''(G) Coordination with the principal nonprofessional caregiver in the home.

''(H) Managing and facilitating transitions among health care professionals and across settings of care.

''(I) Activities that facilitate continuity of care and patient adherence to plans of care.

''(J) Such other services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate.

''(2) For purposes of this subsection, the term 'qualified frail elderly or at-risk individual' means an individual who a care coordinator certifies—

''(A) is at risk of institutionalization, functional decline, or death because the individual is an individual—

''(i) with 2 or more serious and disabling chronic conditions;

''(ii) who is unable to carry out 2 or more than activities of daily living (as described in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) without the assistance of another individual or the use of an assistive device;

''(iii) who is cognitively impaired or has severe depression;

''(iv) who has a poor self-rating of health status, as determined using a survey instrument specified by the Secretary, such as SF 36;

''(v) who, because of their physical or mental condition, would satisfy the requirements (other than with respect to income and assets) for receiving nursing facility services under the medicaid program in the individual's State of residence; or

''(vi) for whom professional coordination of care and assessment can reasonably be expected to improve outcomes of health care or prevent, delay, or minimize disability progression; or

''(B) has a severity of condition that makes the individual frail or disabled (as determined under guidelines approved by the Secretary).

''(3)(A) For purposes of this subsection, the term 'care coordinator' means an individual or entity that—

''(i) is—

''(I) a physician (as defined in subsection (r)(1)); or

''(II) a practitioner described in section 1842(b)(18)(C) or an entity that meets such conditions as the Secretary may specify (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) and that is under the appropriate supervision of a physician;

''(ii) has entered into a care coordination agreement with the Secretary; and

''(iii) meets such other criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physicians' services).

''(B) For purposes of subparagraph (A)(ii), each care coordination agreement shall—

''(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in subparagraph (A);

''(ii) assure the compliance of the care coordinator with such data collection and reporting requirements as the Secretary determines necessary to assess the effect of care coordination on health outcomes; and

''(iii) contain such other terms and conditions as the Secretary may require.''.

(c) PAYMENT AND ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 223(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–489), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(A) by striking ''and (U)'' and inserting ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to care coordination and assessment services de-

scribed in section 1861(s)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to care coordination and assessment services (as defined in section 1861(ww)(1)),''.

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by section 105(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–472), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by adding at the end the following new clause:

''(vii) A care coordinator (as defined in section 1861(ww)(3)) that is not a physician.''.

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

''(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is—

''(A) a care coordination and assessment service (as defined in section 1861(ww)(1)); and

''(B) provided by a care coordinator (as defined in paragraph (3) of such section).''.

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

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to care coordination and assessment services furnished on or after January 1, 2002.

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