108TH CONGRESS
1ST SESSION

S. 387

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

IN THE SENATE OF THE UNITED STATES

FEBRUARY 13, 2003

Mrs. LINCOLN (for herself, Mr. REID, Ms. SNOWE, Mr. BREAUX, Mr. GRAHAM of Florida, Mr. BINGAMAN, Ms. LANDRIEU, Mrs. MURRAY, Ms. MIKULSKI, Mr. SARBANES, Mr. REED, Mr. KENNEDY, 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 extend the eligibility periods for geriatric graduate medical education, to permit the expansion of medical residency training programs in geriatric medicine, to provide for reimbursement of care coordination and assessment services provided under the medicare program, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Geriatric Care Act of 2003''.

(b) TABLE OF CONTENTS.—

SEC. 2. EXTENSION OF ELIGIBILITY PERIODS FOR GERIATRIC GRADUATE MEDICAL EDUCATION.

(a) DIRECT GME.—Section 1886(h)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amended by adding at the end the following new clause:

''(vi) GERIATRIC RESIDENCY AND FELLOWSHIP PROGRAMS.—In the case of an individual enrolled in a geriatric residency or fellowship program approved by the Secretary for purposes of subparagraph (A), the period of board eligibility and the initial residency period shall be the period of board eligibility for the subspecialty involved, plus 1 year.''.

(b) CONFORMING AMENDMENT.—Section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) is amended by striking ''subparagraph (G)(v)'' and inserting ''clauses (v) and (vi) of subparagraph (G)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after the date that is 6 months after the date of enactment of this Act.

SEC. 3. 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 2003, 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, rural health clinic, or Federally qualified health center, the Secretary shall not take into account a maximum of 3 residents enrolled in a fellowship or residency in geriatric medicine or geriatric psychiatry within an approved medical

residency training program to the extent that the hospital, rural health clinic, or Federally qualified health center increases the number of such residents above the number of such residents for the hospital's, rural health clinic's, or Federally qualified health center'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), insofar as such clause applies with respect to hospitals, 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. 4. 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)) is amended—

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

(2) in subparagraph (V)(iii), by adding ''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) is amended by adding at the end the following new subsection:

''Care Coordination and Assessment Services; Individual With a Serious and Disabling Chronic Condition; Care Coordinator

''(ww)(1) The term 'care coordination and assessment services' means services that are furnished to an individual with a serious and disabling chronic condition (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)(i)(I) An initial assessment of an individual's medical condition, functional and cognitive capacity, and environmental and psychosocial needs.

''(II) Annual assessments after the initial assessment performed under subclause (I), unless the physician or care coordinator of the individual determines that additional assessments are required due to sentinel health events or changes in the health status of the individual that may require changes in plans of care developed for the individual.

''(ii) The development of an initial plan of care, and subsequent appropriate revisions to that plan of care.

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

''(iv) The monitoring and management of medications.

''(v) Patient education and counseling services.

''(vi) Family caregiver education and counseling services.

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

''(viii) Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour avail-

ability of such professionals for emergency consultations.

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

''(x) Managing and facilitating transitions among health care professionals and across settings of care, including the following:

''(I) Pursuing the treatment option elected by the individual.

''(II) Including any advance directive executed by the individual in the medical file of the individual.

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

''(xii) Information about, and referral to, hospice services, including patient and family caregiver education and counseling about hospice, and facilitating transition to hospice when elected.

''(xiii) Such other medical and health care services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate for effective care coordination, including the additional items and services as described in subparagraph (B).

''(B) The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to eligible beneficiaries who have made an election under this section (subject to an assessment by the care coordinator of an individual beneficiary's circumstances and need for such benefits) in order to encourage the receipt of, or to improve the effectiveness of, care coordination services.

''(2) For purposes of this subsection, the term 'individual with a serious and disabling chronic condition' means an individual who a care coordinator annually certifies—

''(A) is unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in paragraph (4)) for a period of at least 60 days due to a loss of functional capacity;

''(B) has a level of disability similar to the level of disability described in subparagraph (A) (as determined under regulations promulgated by the Secretary);

''(C) has a complex medical condition (as defined by the Secretary) that requires medical management and coordination of care; or

''(D) requires substantial supervision to protect such individual from threats to health and safety due to a severe cognitive impairment (as defined by the Secretary) or mental condition (as defined 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) working in collaboration with 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 that the care coordinator will submit reports to the Secretary on the functional and medical status of individuals with a chronic and disabling condition who receive care coordination services, expenditures relating to such services, and health outcomes relating to such services, except that the Secretary may not require a care coordinator to submit more than 1 such report during a year; and

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

''(4) For purposes of this subsection, the term 'activities of daily living' means each of the following:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(5) Rural health clinics and Federally qualified health centers shall be eligible sites at which care coordination and assessment services may be provided.''.

(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)) is amended—

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

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to care coordination and assessment services described 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) of the Social Security Act (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)) 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, 2004.

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