

111TH CONGRESS
1ST SESSION

S. 1004

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

IN THE SENATE OF THE UNITED STATES

MAY 7, 2009

Mrs. LINCOLN (for herself and Ms. COLLINS) 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 provide Medicare beneficiaries with access to geriatric assessments and chronic care management and coordination services, 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 “The Reaching Elders with Assessment and Chronic Care
6 Management and Coordination Act” or the “RE-Aligning
7 Care Act”.

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

- 3 Sec. 1. Short title; table of contents.
- 4 Sec. 2. Findings.
- 5 Sec. 3. Medicare coverage of geriatric assessments.
- 6 Sec. 4. Medicare coverage of chronic care management and coordination serv-
7 ices.
- 8 Sec. 5. Outreach activities regarding geriatric assessments and chronic care
9 management and coordination services under the Medicare pro-
10 gram.
- 11 Sec. 6. Utilization of telehealth services to furnish geriatric assessments and
12 chronic care management and coordination services under the
13 Medicare program.
- 14 Sec. 7. Study and report on geriatric assessments and chronic care manage-
15 ment and coordination services under the Medicare program.
- 16 Sec. 8. Rule of construction.

3 **SEC. 2. FINDINGS.**

4 Congress makes the following findings:

5 (1) The Medicare program must be redesigned
6 to provide high-quality, cost-effective and coordi-
7 nated care to the growing population of elderly indi-
8 viduals with multiple and complex chronic condi-
9 tions.

10 (2) Between 2005 and 2030, it is estimated
11 that the number of adults aged 65 and older will al-
12 most double from 37,000,000 to more than
13 70,000,000. The number of those age 80 and over,
14 is also expected to nearly double from 11,000,000 to
15 20,000,000. This demographic shift will create the
16 largest ever proportion of adults over 65, increasing
17 from 12 percent of the United States population in
18 2005 to almost 20 percent by 2030.

1 (3) With the unprecedented growth of our Na-
2 tion's aging population, the number of older patients
3 with multiple chronic conditions and cognitive im-
4 pairments is expected to increase. Currently, about
5 65 percent of Medicare beneficiaries have two or
6 more chronic conditions. To address the health care
7 needs unique to older adults with chronic conditions,
8 it will require innovations in care delivery and com-
9 prehensive coordinated care.

10 (4) According to the Congressional Budget Of-
11 fice, approximately 75 percent of Medicare spending
12 pays for care for beneficiaries who have five or more
13 chronic conditions and see an average of 14 different
14 physicians per year. In addition, approximately 43
15 percent of Medicare costs can be attributed to 5 per-
16 cent of Medicare's most costly beneficiaries.

17 (5) Total Medicare costs per beneficiary age 65
18 or older with Alzheimer's and other dementias were
19 almost three times higher than for other Medicare
20 beneficiaries in 2004.

21 (6) There is a strong pattern of increasing utili-
22 zation as the number of conditions increase. In
23 2003, 61 percent of Medicare beneficiaries with 3
24 chronic conditions saw 10 or more different physi-

1 cians compared to 40 percent with 2 conditions and
2 18 percent of those with 1 condition.

3 (7) According to a June 2006 MedPAC report,
4 even if individual providers deliver care efficiently,
5 overall care for a beneficiary may be inefficient if
6 providers do not coordinate across settings or assist
7 beneficiaries in managing their conditions between
8 visits. Beneficiaries with multiple chronic conditions
9 may benefit the most from care coordination as they
10 do not always receive necessary care and often at
11 high cost.

12 (8) On average, individuals 65 to 69 years old
13 take nearly 14 prescriptions per year and individuals
14 aged 80 to 84 take an average of 18 prescriptions
15 per year. As the number of chronic conditions in-
16 creases, so does the number of medications, increas-
17 ing the risk for negative drug interactions that can
18 lead to serious injury requiring hospitalization or
19 can even be fatal. Studies have found that 25 per-
20 cent to 50 percent adverse drug events among older
21 persons are preventable and that preventable adverse
22 drug events may cost the Medicare program
23 \$887,000,000 per year.

24 (9) Research conducted in the United States
25 and internationally indicate that the delivery of high-

1 er quality health care, increased efficiency, and cost-
2 effectiveness are the result of systems in which pa-
3 tients are linked with a physician or another quali-
4 fied health professional who coordinates their care.
5 According to the Congressional Budget Office, an
6 intervention that focused on coordinating care for
7 high-cost beneficiaries with multiple chronic condi-
8 tions could both improve their health and reduce
9 Medicare spending.

10 (10) In addition, chronic care management and
11 coordination may help prevent negative medication
12 interactions and prevent hospital stays because the
13 chronic care team holistically manages and treats ill-
14 ness. Reducing the rate of preventable adverse drug
15 events will both improve patient care and may result
16 in savings to the Medicare program.

17 (11) The Medicare fee-for-service program cur-
18 rently does not pay for care coordination services.
19 Instead, the delivery and payment systems are orga-
20 nized to support the diagnosis and treatment of
21 acute or episodic conditions, resulting in fragmented,
22 ineffective and costly care for beneficiaries with
23 chronic diseases. It currently rewards the overuse
24 and duplication of services rather than rewarding
25 the effective control of chronic conditions, which can

1 improve health outcomes and prevent hospitalization
2 or rehospitalization.

3 (12) The Institute of Medicine Report, “Retool-
4 ing for an Aging America: Building the Health Care
5 Workforce”, cited misaligned financial incentives, in-
6 cluding the inability to reimburse for care coordina-
7 tion, as factors that result in fragmented care for
8 older Americans.

9 (13) Financial incentives within the Medicare
10 program should be realigned as part of a com-
11 prehensive system change. The Medicare program
12 should be restructured to reimburse physicians and
13 other qualified health professionals for the cost of
14 coordinating care.

15 (14) The patient-centered chronic care model
16 established by the provisions of, and the amend-
17 ments made by, this Act includes several elements
18 that are effective in managing older adults with
19 chronic disease, including—

20 (A) a comprehensive assessment of the in-
21 dividual’s physical, cognitive, affective, func-
22 tional and social status, and caregiving needs;

23 (B) access to patient-centered care coordi-
24 nation services provided by interdisciplinary
25 team members;

1 (C) support for patient self-management of
2 chronic disease;

3 (D) linkages with community resources;

4 (E) health care system changes that re-
5 ward quality chronic care;

6 (F) practice redesign;

7 (G) evidence-based clinical practice guide-
8 lines; and

9 (H) clinical information systems, such as
10 electronic medical records and continuity of
11 care records.

12 (15) The provisions of, and amendments made
13 by, this Act are intended to—

14 (A) improve health outcomes appropriate
15 for older patients with multiple chronic condi-
16 tions;

17 (B) increase beneficiary, caregiver, and
18 provider satisfaction;

19 (C) increase cost-effectiveness and high
20 value to the Medicare program for those served
21 with multiple chronic conditions;

22 (D) establish a process to identify those
23 Medicare beneficiaries most likely to benefit
24 from having a provider coordinate their health
25 care needs; and

1 (E) establish a payment under the Medi-
 2 care program for—

3 (i) the assessment of those health care
 4 needs; and

5 (ii) the activities required to coordi-
 6 nate those health care needs.

7 **SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESS-**
 8 **MENTS.**

9 (a) COVERAGE OF GERIATRIC ASSESSMENTS.—

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

13 (A) in subparagraph (DD), by striking
 14 “and” at the end;

15 (B) in subparagraph (EE), by adding
 16 “and” at the end; and

17 (C) by adding at the end the following new
 18 subparagraph:

19 “(FF) geriatric assessments (as defined in sub-
 20 section (hhh)(1));”.

21 (2) CONFORMING AMENDMENTS.—Clauses (i)
 22 and (ii) of section 1861(s)(2)(K) of the Social Secu-
 23 rity Act (42 U.S.C. 1395x(s)(2)(K)) are each
 24 amended by striking “subsection (ww)(1)” and in-
 25 serting “subsections (ww)(1) and (hhh)(1)”.

1 (b) GERIATRIC ASSESSMENTS DEFINED.—Section
2 1861 of the Social Security Act (42 U.S.C. 1395x) is
3 amended by adding at the end the following new sub-
4 sections:

5 “Geriatric Assessment

6 “(hhh)(1) The term ‘geriatric assessment’ means
7 each of the following:

8 “(A) An assessment of the clinical status, func-
9 tional status, social and environmental functioning,
10 and need for caregiving of a geriatric assessment eli-
11 gible individual (as defined in subsection (iii)). The
12 assessment shall include a comprehensive history
13 and physical examination and assessments of the fol-
14 lowing domains using standardized validated clinical
15 tools:

16 “(i) Comprehensive review of medications
17 and the individual’s adherence to the medica-
18 tion regimen.

19 “(ii) Measurement of affect, cognition and
20 executive function, mobility, balance, gait, risk
21 of falling, and sensory function.

22 “(iii) Social functioning, environmental
23 needs, and caregiver resources and needs.

24 “(iv) Any other domain determined appro-
25 priate by the Secretary.

1 “(B) The development of a written care plan
2 based on the results of the assessment under sub-
3 paragraph (A) (and any subsequent assessment
4 under subparagraph (B)). The care plan shall detail
5 identified problems, outline therapies, assign respon-
6 sibility for actions, and indicate whether the indi-
7 vidual is likely to benefit from chronic care manage-
8 ment and coordination services (as defined in sub-
9 section (jjj)(1)). If the individual is determined likely
10 to benefit from chronic care management and co-
11 ordination services, the care plan shall also provide
12 the basis for the chronic care management and co-
13 ordination plan to be developed by the chronic care
14 manager pursuant to subsection (jjj).

15 “(2) A geriatric assessment may only be conducted
16 by—

17 “(A) a physician;

18 “(B) a practitioner described in section
19 1842(b)(18)(C)(i) under the supervision of a physi-
20 cian; or

21 “(C) any other provider that meets such condi-
22 tions as the Secretary may specify.

23 “(3) An individual described in subclause (A), (B),
24 or, if applicable, (C) may provide for the furnishing of

1 services included in the geriatric assessment by other
2 qualified health care professionals.

3 “(4)(A) Subject to subparagraph (B), a geriatric as-
4 sessment of a geriatric assessment eligible individual may
5 not be conducted more frequently than annually.

6 “(B) A geriatric assessment of a geriatric assessment
7 eligible individual may be conducted more frequently than
8 annually if the assessment is medically necessary due to
9 a significant change in the condition of the individual.

10 “Geriatric Assessment Eligible Individual

11 “(iii)(1) Subject to paragraph (3), the term ‘geriatric
12 assessment eligible individual’ means an individual identi-
13 fied by the Secretary as eligible for a geriatric assessment.

14 “(2) In identifying individuals under paragraph (1),
15 the following rules shall apply:

16 “(A) The individual must have at least 1 of the
17 following present:

18 “(i) Multiple chronic conditions that the
19 Secretary identifies as likely to result in high
20 expenditures under this title. In identifying
21 such conditions, the Secretary may consider—

22 “(I) the hierarchal condition category
23 methodology employed for risk adjustment
24 under part C or other comparable meth-
25 odologies the Secretary deems appropriate;

1 “(II) data from the Chronic Condition
2 Data Warehouse under section 723 of the
3 Medicare Prescription Drug, Improvement,
4 and Modernization Act of 2003; and

5 “(III) indicators of geriatric syn-
6 dromes, such as experiencing 2 or more
7 falls in the past year, urinary incontinence,
8 clinically significant depression, or other
9 such indicators that the Secretary indicates
10 as likely to result in high expenditures
11 under this title when they exist in com-
12 bination with one or more chronic condi-
13 tions).

14 “(ii) Dementia, as defined in the most re-
15 cent Diagnostic and Statistical Manual of Men-
16 tal Disorders, and at least 1 other chronic con-
17 dition.

18 “(iii) Any other factor identified by the
19 Secretary.

20 “(B) The Secretary shall consult with physi-
21 cians, physician groups and organizations, other
22 health care professional groups and organizations,
23 organizations representing individuals with chronic
24 conditions and older adults, and other stakeholders
25 in identifying conditions under clauses (i) and (ii) of

1 subparagraph (A) and any factors under subpara-
2 graph (A)(iii).

3 “(3) The term ‘geriatric assessment eligible indi-
4 vidual’ shall not include the following individuals:

5 “(A) An individual who is receiving hospice care
6 under this title.

7 “(B) An individual who is residing in a skilled
8 nursing facility, a nursing facility (as defined in sec-
9 tion 1919), or any other facility identified by the
10 Secretary.

11 “(C) An individual medically determined to
12 have end-stage renal disease.

13 “(D) An individual enrolled in a Medicare Ad-
14 vantage plan or a plan under section 1876.

15 “(E) An individual enrolled in a PACE pro-
16 gram under section 1894.

17 “(F) Any other categories of individuals deter-
18 mined appropriate by the Secretary.

19 “(4) For purposes of this subsection, the term ‘chron-
20 ic condition’ means a condition, such as dementia, that
21 lasts or is expected to last 1 year or longer, limits what
22 an individual can do, and requires ongoing care.”.

23 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
24 ING.—

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

4 (A) in subparagraph (N), by inserting
5 “other than geriatric assessments (as defined in
6 section 1861(hhh)(1))” after “(as defined in
7 section 1848(j)(3))”;

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

9 (C) by inserting before the semicolon at
10 the end the following: “, and (X) with respect
11 to geriatric assessments (as defined in section
12 1861(hhh)(1)), the amount paid shall be 100
13 percent of the lesser of the actual charge for
14 the services or the amount determined under
15 section 1848(o)”.

16 (2) PAYMENT.—

17 (A) IN GENERAL.—Section 1848 of the So-
18 cial Security Act (42 U.S.C. 1395w-4) is
19 amended by adding at the end the following
20 new subsection:

21 “(o) PAYMENT FOR GERIATRIC ASSESSMENTS.—

22 “(1) ESTABLISHMENT.—

23 “(A) IN GENERAL.—The Secretary shall
24 establish—

1 “(i) a payment code (or codes) under
2 this section for a geriatric assessment (as
3 defined in section 1861(hhh)(1)) furnished
4 to a geriatric assessment eligible individual
5 (as defined in section 1861(iii)) by a physi-
6 cian, practitioner, or other provider de-
7 scribed in section 1861(hhh)(2); and

8 “(ii) a payment amount for each such
9 code.

10 “(B) REQUIREMENTS.—In establishing
11 payment amounts under subparagraph (A)(ii),
12 the Secretary shall—

13 “(i) take into account—

14 “(I) the amount of work required
15 to perform a geriatric assessment, in-
16 cluding the time and effort put forth
17 by each qualified health care profes-
18 sional involved in performing the geri-
19 atric assessment; and

20 “(II) all of the costs associated
21 with the geriatric assessment, includ-
22 ing labor, supplies, equipment, and
23 the costs of health information tech-
24 nologies and systems incurred by the
25 physician, practitioner, or other pro-

1 vider (as described in section
2 1861(hhh)(2)) in providing the assess-
3 ment; and

4 “(ii) ensure that such payments do
5 not result in a reduction in payments for
6 office visits or other evaluation and man-
7 agement services that would otherwise be
8 allowable.

9 “(2) SEPARATE PAYMENTS FROM PAYMENTS
10 FOR CHRONIC CARE MANAGEMENT AND COORDINA-
11 TION SERVICES.—Payments for geriatric assess-
12 ments shall be made separately from payments for
13 chronic care management and coordination services
14 (as defined in section 1861(jjj)(1)) and other serv-
15 ices for which payment is made under this title.”.

16 (B) CONFORMING AMENDMENT.—Section
17 1848(j)(3) of the Social Security Act (42
18 U.S.C. 1395w-4(j)(3)), as amended by section
19 3(e)(2), is amended by inserting “(2)(FF),”
20 after “(2)(EE),”.

21 (3) ELIMINATION OF COINSURANCE IN OUT-
22 PATIENT HOSPITAL SETTINGS.—

23 (A) EXCLUSION FROM OPD FEE SCHED-
24 ULE.—Section 1833(t)(1)(B)(iv) of the Social
25 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is

1 amended by striking “and diagnostic mammog-
 2 raphy” and inserting “, diagnostic mammog-
 3 raphy, or geriatric assessments (as defined in
 4 section 1861(hhh)(1))”.

5 (B) CONFORMING AMENDMENTS.—Section
 6 1833(a)(2) of the Social Security Act (42
 7 U.S.C. 1395l(a)(2)) is amended—

8 (i) in subparagraph (F), by striking
 9 “and” at the end;

10 (ii) in subparagraph (G)(ii), by strik-
 11 ing the comma at the end and inserting “;
 12 and”; and

13 (iii) by inserting after subparagraph
 14 (G)(ii) the following new subparagraph:

15 “(H) with respect to geriatric assessments
 16 (as defined in section 1861(hhh)(1)) furnished
 17 by an outpatient department of a hospital, the
 18 amount determined under paragraph (1)(X),”.

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

22 (A) by striking “and” before “(9)”; and

23 (B) by inserting before the period the fol-
 24 lowing: “, and (10) such deductible shall not

1 apply with respect to geriatric assessments (as
2 defined in section 1861(hhh)(1))”.

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

6 (1) in paragraph (1)—

7 (A) in subparagraph (N), by striking
8 “and” at the end;

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

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

13 “(P) in the case of geriatric assessments (as de-
14 fined in section 1861(hhh)(1)), which are performed
15 more frequently than is covered under such sec-
16 tion;”; and

17 (2) in paragraph (7), by striking “or (K)” and
18 inserting “(K), or (P)”.

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

23 “(6) GERIATRIC ASSESSMENTS.—In the case of
24 a designated health service, if the designated health

1 service is a geriatric assessment (as defined in sec-
2 tion 1861(hhh)(1)) and furnished by a physician.”.

3 (f) RULEMAKING.—The Secretary of Health and
4 Human Services shall define such terms, establish such
5 procedures, and promulgate such regulations as the Sec-
6 retary determines necessary to implement the amend-
7 ments made by, and the provisions of, this section, includ-
8 ing the establishment of additional domains under sub-
9 section (hhh)(1)(A)(iv) of section 1861 of the Social Secu-
10 rity Act, as added by subsection (b). In promulgating such
11 regulations, the Secretary shall consult with physicians,
12 physician groups and organizations, other health care pro-
13 fessional groups and organizations representing individ-
14 uals with chronic conditions and older adults.

15 (g) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to assessments furnished on or
17 after January 1, 2010.

18 **SEC. 4. MEDICARE COVERAGE OF CHRONIC CARE MANAGE-**
19 **MENT AND COORDINATION SERVICES.**

20 (a) PART B COVERAGE OF CHRONIC CARE MANAGE-
21 MENT AND COORDINATION SERVICES.—

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

1 (A) in subparagraph (EE), by striking
2 “and” at the end;

3 (B) in subparagraph (FF), by adding
4 “and” at the end; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(GG) chronic care management and coordina-
8 tion services (as defined in subsection (jjj));”.

9 (2) CONFORMING AMENDMENTS.—(A) Clauses
10 (i) and (ii) of section 1861(s)(2)(K) of the Social Se-
11 curity Act (42 U.S.C. 1395x(s)(2)(K)), as amended
12 by section 3(a)(2), are each amended by striking
13 “subsections (ww)(1) and (hhh)(1)” and inserting
14 “subsections (ww)(1), (hhh)(1), and (jjj)(1)”.

15 (B) Section 1862(a)(7) of the Social Security
16 Act (42 U.S.C. 1395y(a)(7)), as amended by section
17 3(d), is amended by striking “section 1861(s)(10)”
18 and inserting “paragraphs (2)(GG) and (10) of sec-
19 tion 1861(s)”.

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

1 “Chronic Care Management and Coordination Services;
2 Chronic Care Manager; Chronic Care Eligible Individual
3 “(jjj)(1) The term ‘chronic care management and co-
4 ordination services’ means services that are furnished to
5 a chronic care eligible individual (as defined in paragraph
6 (3)) by, or under the supervision of, a single chronic care
7 manager (as defined in paragraph (2)) chosen by the
8 chronic care eligible individual, a caregiver designated by
9 the individual in writing, or a representative authorized
10 to make decisions on the individual’s behalf, under a plan
11 of care prescribed by such chronic care manager for the
12 purpose of chronic care coordination, including dementia
13 as appropriate, which may include any of the following
14 services:

15 “(A) The development of an initial plan of care
16 (based on the results of a geriatric assessment, as
17 defined in subsection (hhh)), and subsequent appro-
18 priate revisions to that plan of care.

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

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

25 “(D) Patient education and counseling services.

1 “(E) Family caregiver education and counseling
2 services, including preventive care consistent with
3 the patient’s condition.

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 individuals, and care-
8 givers or authorized representatives as appropriate,
9 by telephone and email to physicians or other appro-
10 priate health care professionals, including 24-hour
11 availability of such professionals for after hours con-
12 sultation.

13 “(H) Coordination with the principal nonprofes-
14 sional caregiver in the home.

15 “(I) Managing and facilitating transitions that
16 occur among health care professionals and across
17 settings of care, including the following:

18 “(i) Pursuing the treatment option elected
19 by the individual.

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

23 “(J) Information about pain management and
24 palliative care.

1 “(K) Information about, and referral to, hos-
2 pice care, including patient and family caregiver
3 education and counseling about hospice care, and fa-
4 cilitating transition to hospice care when elected.

5 “(L) Information about, referral to, and coordi-
6 nation with, community resources.

7 “(M) Such additional services for which pay-
8 ment would not otherwise be made under this title
9 that the Secretary may specify that encourage the
10 receipt of, or improve the effectiveness of, the serv-
11 ices described in the preceding subparagraphs.

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

15 “(i) is—

16 “(I) a physician;

17 “(II) a practitioner described in clause (i)
18 or (iv) of section 1842(b)(18)(C); or

19 “(III) any other provider that meets such
20 conditions as the Secretary may specify;

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

24 “(iii) is working in collaboration with, or under
25 the supervision of, as determined by the Secretary—

1 “(I) the physician, practitioner, or other
2 provider who completed the geriatric assessment
3 of the individual; or

4 “(II) a physician, practitioner, or other
5 provider to whom the individual’s care was
6 transferred by the physician, practitioner, or
7 other provider who performed the geriatric as-
8 sessment.

9 “(B)(i) For purposes of subparagraph (A)(ii), each
10 chronic care management and coordination agreement
11 shall meet the requirements described in subparagraph
12 (C) and shall—

13 “(I) subject to clause (ii), be entered into for a
14 period of 3 years and may be renewed if the Sec-
15 retary is satisfied that the chronic care manager
16 continues to meet such terms and conditions as the
17 Secretary may require; and

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

20 “(ii) Each chronic care management and coordination
21 agreement shall provide for the termination of such agree-
22 ment prior to such 3-year period in the case where the
23 chronic care manager—

24 “(I) is no longer able to provide chronic care
25 services; or

1 “(II) does not meet such terms and conditions
2 as the Secretary may require.

3 “(C)(i) Subject to clause (ii), the requirements of this
4 subparagraph are met if the agreement requires the chron-
5 ic care manager to perform, or provide for the perform-
6 ance of, the following services:

7 “(I) Advocating for, and providing ongoing sup-
8 port, oversight, and guidance with respect to the im-
9 plementation of a plan of care that provides an inte-
10 grated, coherent, and cross-disciplined plan for ongo-
11 ing medical care that is developed in partnership
12 with the chronic care eligible individual and all other
13 physicians and other care providers and agencies (in-
14 cluding home health agencies) providing care to the
15 chronic care eligible individual.

16 “(II) Using evidence-based medicine and clin-
17 ical decision support tools to guide decision making
18 at the point of care and on the basis of specific pa-
19 tient factors.

20 “(III) Using health information technology, in-
21 cluding, where appropriate, remote monitoring and
22 patient registries, to monitor and track the health
23 status of patients and to provide patients with en-
24 hanced and convenient access to health care services.

1 “(IV) Encouraging patients to engage in the
2 management of their own health through education
3 and support systems.

4 “(V) Incorporating family caregivers into the
5 chronic care planning process.

6 “(ii) The Secretary may modify the services required
7 under the agreement under clause (i), including by requir-
8 ing different services or services in addition to those de-
9 scribed in subclauses (I) through (V) of such clause.

10 “(D) The Secretary shall adopt procedures which ex-
11 empt providers in rural areas from providing 1 or more
12 of the services otherwise required to be provided under
13 subparagraph (C) or modify such requirements for such
14 providers. In establishing such procedures, the Secretary
15 shall ensure that such exemptions and modifications do
16 not impact the quality of chronic care management and
17 coordination services furnished by such providers.

18 “(3) For purposes of this subsection, the term ‘chron-
19 ic care eligible individual’ means a geriatric assessment
20 eligible individual (as defined in subsection (iii)) who has
21 undergone a geriatric assessment (as defined in subsection
22 (hhh)(1)) which determined that the individual would ben-
23 efit from chronic care management and coordination.

1 “(4) Chronic care management and coordination
 2 services may be furnished in the chronic care eligible indi-
 3 vidual’s home or residence.”.

4 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
 5 ING.—

6 (1) PAYMENT AND ELIMINATION OF COINSUR-
 7 ANCE.—Section 1833(a)(1) of the Social Security
 8 Act (42 U.S.C. 1395l(a)(1)), as amended by section
 9 3(c)(1), is amended—

10 (A) in subparagraph (N), by inserting “or
 11 chronic care management and coordination
 12 services (as defined in section 1861(jjj)(1))”
 13 after “other than geriatric assessments (as de-
 14 fined in section 1861(hhh)(1))”;

15 (B) by striking “and” before “(X)”; and

16 (C) by inserting before the semicolon at
 17 the end the following: “, and (Y) with respect
 18 to chronic care management and coordination
 19 services (as defined in section 1861(jjj)(1)), the
 20 amount paid shall be 100 percent of the lesser
 21 of the actual charge for the services or the
 22 amount determined under section 1848(p)”.

23 (2) PAYMENT.—

24 (A) IN GENERAL.—Section 1848 of the So-
 25 cial Security Act (42 U.S.C. 1395w-4), as

1 amended by section 3(c)(2), is amended by add-
2 ing at the end the following new subsection:

3 “(p) PAYMENT FOR CHRONIC CARE MANAGEMENT
4 AND COORDINATION SERVICES.—

5 “(1) ESTABLISHMENT.—

6 “(A) IN GENERAL.—The Secretary shall
7 establish—

8 “(i) a payment code (or codes) under
9 this section for chronic care management
10 and coordination services (as defined in
11 paragraph (1) of section 1861(jjj)) fur-
12 nished to a chronic care eligible individual
13 (as defined in paragraph (3) of such sec-
14 tion) by a chronic care manager (as de-
15 fined in paragraph (2) of such section);
16 and

17 “(ii) a payment amount for each such
18 code.

19 “(B) REQUIREMENTS.—In establishing
20 payment amounts under subparagraph (A)(ii),
21 the Secretary shall—

22 “(i) take into account—

23 “(I) the amount of work required
24 of the chronic care manager in pro-
25 viding chronic care management and

1 coordination services to eligible indi-
2 viduals; and

3 “(II) all of the costs associated
4 with providing chronic care manage-
5 ment and coordination services, in-
6 cluding labor, supplies, equipment,
7 and the costs of health information
8 technologies and systems incurred by
9 the chronic care manager in providing
10 such services;

11 “(ii) ensure that such payments are
12 for such services furnished during a 30-day
13 period; and

14 “(iii) ensure that such payments do
15 not result in a reduction in payments for
16 office visits or other evaluation and man-
17 agement services that would otherwise be
18 allowable.

19 “(2) SEPARATE PAYMENTS FROM PAYMENTS
20 FOR GERIATRIC ASSESSMENTS.—Payments for
21 chronic care management and coordination services
22 shall be made separately from payments for geriatric
23 assessments (as defined in section 1861(hhh)(1))
24 and other services for which payment is made under
25 this title.”.

1 (B) CONFORMING AMENDMENT.—Section
2 1848(j)(3) of the Social Security Act (42
3 U.S.C. 1395w–4(j)(3)), as amended by section
4 3(e)(2), is amended by inserting “(2)(GG),”
5 after “(2)(FF),”.

6 (3) ELIMINATION OF COINSURANCE IN OUT-
7 PATIENT HOSPITAL SETTINGS.—

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

18 (B) CONFORMING AMENDMENTS.—Section
19 1833(a)(2) of the Social Security Act (42
20 U.S.C. 1395l(a)(2)), as amended by section
21 3(e)(3)(B), is amended—

22 (i) in subparagraph (G)(ii), by strik-
23 ing “and” 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 and coordination services (as defined in
8 section 1861(jjj)(1)) furnished by an outpatient
9 department of a hospital, the amount deter-
10 mined under paragraph (1)(Y),”.

11 (4) ELIMINATION OF DEDUCTIBLE.—Paragraph
12 (10) of section 1833(b) of the Social Security Act
13 (42 U.S.C. 1395l(b)), as added by section 3(e)(4), is
14 amended by inserting “or chronic care management
15 and coordination services (as defined in section
16 1861(jjj)(1))” after “geriatric assessments (as de-
17 fined in section 1861(hhh)(1))”.

18 (d) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
19 RALS.—Section 1877(b)(6) of the Social Security Act (42
20 U.S.C. 1395nn(b)(6)), as amended by section 3(e), is
21 amended to read as follows:

22 “(6) GERIATRIC ASSESSMENTS AND CHRONIC
23 CARE MANAGEMENT AND COORDINATION SERV-
24 ICES.—In the case of a designated health service, if
25 the designated health service is—

1 “(A) a geriatric assessment or a chronic
2 care management and coordination service (as
3 defined in subsections (hhh)(1) or (jjj)(1) of
4 section 1861, respectively); and

5 “(B) furnished by a physician.”.

6 (e) RULEMAKING.—The Secretary of Health and
7 Human Services shall define such terms, establish such
8 procedures, and promulgate such regulations as the Sec-
9 retary determines necessary to implement the amend-
10 ments made by, and the provisions of, this section. In pro-
11 mulgating such regulations, the Secretary shall consult
12 with physicians, physician groups and organizations, other
13 health care professional groups and organizations, and or-
14 ganizations representing individuals with chronic condi-
15 tions and older adults.

16 (f) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to chronic care management and
18 coordination services furnished on or after January 1,
19 2010.

20 **SEC. 5. OUTREACH ACTIVITIES REGARDING GERIATRIC AS-**
21 **SESSMENTS AND CHRONIC CARE MANAGE-**
22 **MENT AND COORDINATION SERVICES UNDER**
23 **THE MEDICARE PROGRAM.**

24 The Secretary of Health and Human Services shall
25 conduct outreach activities to individuals likely to be eligi-

1 ble to receive coverage of geriatric assessments (as defined
 2 in subsection (hhh)(1) of section 1861 of the Social Secu-
 3 rity Act, as added by section 3) under the Medicare pro-
 4 gram and individuals likely to be eligible to receive cov-
 5 erage of chronic care management and coordination serv-
 6 ices (as defined in subsection (jjj)(1) of such section 1861,
 7 as added by section 4) under the Medicare program, to
 8 inform such individuals about the availability of such ben-
 9 efits under the Medicare program.

10 **SEC. 6. UTILIZATION OF TELEHEALTH SERVICES TO FUR-**
 11 **NISH GERIATRIC ASSESSMENTS AND CHRON-**
 12 **IC CARE MANAGEMENT AND COORDINATION**
 13 **SERVICES UNDER THE MEDICARE PROGRAM.**

14 (a) IN GENERAL.—Section 1834(m)(4)(F) of the So-
 15 cial Security Act (42 U.S.C. 1395m(m)(4)(F)) is amended
 16 by adding at the end the following new clause:

17 “(iii) GERIATRIC ASSESSMENTS AND
 18 CHRONIC CARE MANAGEMENT AND CO-
 19 ORDINATION SERVICES.—The term ‘tele-
 20 health service’ shall also include geriatric
 21 assessments (as defined in section
 22 1861(hhh)(1)) and chronic care manage-
 23 ment and coordination services (as defined
 24 in section 1861(jjj)).”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2010.

4 **SEC. 7. STUDY AND REPORT ON GERIATRIC ASSESSMENTS**
5 **AND CHRONIC CARE MANAGEMENT AND CO-**
6 **ORDINATION SERVICES UNDER THE MEDI-**
7 **CARE PROGRAM.**

8 (a) STUDY.—The Secretary of Health and Human
9 Services shall enter into a contract with an entity to con-
10 duct a study on—

11 (1) the effectiveness of the coverage of geriatric
12 assessments and chronic care management and co-
13 ordination services, including an evaluation of the
14 use of interdisciplinary teams in providing such serv-
15 ices, under the Medicare program (under the amend-
16 ments made by sections 3 and 4) on improving the
17 quality of care provided to Medicare beneficiaries
18 with chronic conditions, including dementia; and

19 (2) the impact of such geriatric assessments
20 and care coordination services on reducing expendi-
21 tures under title XVIII of the Social Security Act,
22 including reduced expenditures that may result
23 from—

24 (A) reducing preventable hospital admis-
25 sions;

1 (B) more appropriate use of pharma-
2 ceuticals; and

3 (C) reducing duplicate or unnecessary
4 tests.

5 (b) REPORT.—Not later than 3 years after the date
6 of enactment of this Act, the entity conducting the study
7 under subsection (a) shall submit to Congress and the Sec-
8 retary of Health and Human Services a report on the
9 study, together with recommendations for such legislation
10 or administrative action as such entity determines appro-
11 priate.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as may be
14 necessary to carry out this section.

15 **SEC. 8. RULE OF CONSTRUCTION.**

16 Nothing in the provisions of, or in the amendments
17 made by, this Act shall be construed as requiring an indi-
18 vidual to receive a geriatric assessment (as defined in sec-
19 tion 1861(hhh)(1) of the Social Security Act, as added by
20 section 3(b)) or chronic care management and coordina-
21 tion services (as defined in section 1861(jjj)(1) of such
22 Act, as added by section 4(b)).

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