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

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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 coordination services, 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 ''The Reaching Elders with Assessment and Chronic Care Management and Coordination Act'' or the ''RE-Aligning Care Act''.

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The Medicare program must be redesigned to provide high-quality, cost-effective and coordinated care to the growing population of elderly individuals with multiple and complex chronic conditions.

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

(3) With the unprecedented growth of our Nation's aging population, the number of older patients with multiple chronic conditions and cognitive impairments is expected to increase. Currently, about 65 percent of Medicare beneficiaries have two or more chronic conditions. To address the health care needs unique to older adults with chronic conditions, it will require innovations in care delivery and comprehensive coordinated care.

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

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

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

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

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

(8) On average, individuals 65 to 69 years old take nearly 14 prescriptions per year and individuals aged 80 to 84 take an average of 18 prescriptions per year. As the number of chronic conditions increases, so does the number of medications, increasing the risk for negative drug interactions that can lead to serious injury requiring hospitalization or can even be fatal. Studies have found that 25 percent to 50 percent adverse drug events among older persons are preventable and that preventable adverse drug events may cost the Medicare program $887,000,000 per year.

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

er quality health care, increased efficiency, and cost-effectiveness are the result of systems in which patients are linked with a physician or another qualified health professional who coordinates their care. According to the Congressional Budget Office, an intervention that focused on coordinating care for high-cost beneficiaries with multiple chronic conditions could both improve their health and reduce Medicare spending.

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

(11) The Medicare fee-for-service program currently does not pay for care coordination services. Instead, the delivery and payment systems are organized to support the diagnosis and treatment of acute or episodic conditions, resulting in fragmented, ineffective and costly care for beneficiaries with chronic diseases. It currently rewards the overuse and duplication of services rather than rewarding the effective control of chronic conditions, which can

improve health outcomes and prevent hospitalization or rehospitalization.

(12) The Institute of Medicine Report, ''Retooling for an Aging America: Building the Health Care Workforce'', cited misaligned financial incentives, including the inability to reimburse for care coordination, as factors that result in fragmented care for older Americans.

(13) Financial incentives within the Medicare program should be realigned as part of a comprehensive system change. The Medicare program should be restructured to reimburse physicians and other qualified health professionals for the cost of coordinating care.

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

(A) a comprehensive assessment of the individual's physical, cognitive, affective, functional and social status, and caregiving needs;

(B) access to patient-centered care coordination services provided by interdisciplinary team members;

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

(D) linkages with community resources;

(E) health care system changes that reward quality chronic care;

(F) practice redesign;

(G) evidence-based clinical practice guidelines; and

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

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

(A) improve health outcomes appropriate for older patients with multiple chronic conditions;

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

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

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

(E) establish a payment under the Medicare program for—

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

(ii) the activities required to coordinate those health care needs.

SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESSMENTS.

(a) COVERAGE OF GERIATRIC ASSESSMENTS.—

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

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

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

''(FF) geriatric assessments (as defined in subsection (hhh)(1));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)(1)''.

(b) GERIATRIC ASSESSMENTS DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsections:

''Geriatric Assessment

''(hhh)(1) The term 'geriatric assessment' means each of the following:

''(A) An assessment of the clinical status, functional status, social and environmental functioning, and need for caregiving of a geriatric assessment eligible individual (as defined in subsection (iii)). The assessment shall include a comprehensive history and physical examination and assessments of the following domains using standardized validated clinical tools:

''(i) Comprehensive review of medications and the individual's adherence to the medication regimen.

''(ii) Measurement of affect, cognition and executive function, mobility, balance, gait, risk of falling, and sensory function.

''(iii) Social functioning, environmental needs, and caregiver resources and needs.

''(iv) Any other domain determined appropriate by the Secretary.

''(B) The development of a written care plan based on the results of the assessment under subparagraph (A) (and any subsequent assessment under subparagraph (B)). The care plan shall detail identified problems, outline therapies, assign responsibility for actions, and indicate whether the individual is likely to benefit from chronic care management and coordination services (as defined in subsection (jjj)(1)). If the individual is determined likely to benefit from chronic care management and coordination services, the care plan shall also provide the basis for the chronic care management and coordination plan to be developed by the chronic care manager pursuant to subsection (jjj).

''(2) A geriatric assessment may only be conducted by—

''(A) a physician;

''(B) a practitioner described in section 1842(b)(18)(C)(i) under the supervision of a physician; or

''(C) any other provider that meets such conditions as the Secretary may specify.

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

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

''(4)(A) Subject to subparagraph (B), a geriatric assessment of a geriatric assessment eligible individual may not be conducted more frequently than annually.

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

''Geriatric Assessment Eligible Individual

''(iii)(1) Subject to paragraph (3), the term 'geriatric assessment eligible individual' means an individual identified by the Secretary as eligible for a geriatric assessment.

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

''(A) The individual must have at least 1 of the following present:

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

''(I) the hierarchal condition category methodology employed for risk adjustment under part C or other comparable methodologies the Secretary deems appropriate;

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

''(III) indicators of geriatric syndromes, such as experiencing 2 or more falls in the past year, urinary incontinence, clinically significant depression, or other such indicators that the Secretary indicates as likely to result in high expenditures under this title when they exist in combination with one or more chronic conditions).

''(ii) Dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, and at least 1 other chronic condition.

''(iii) Any other factor identified by the Secretary.

''(B) The Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations, organizations representing individuals with chronic conditions and older adults, and other stakeholders in identifying conditions under clauses (i) and (ii) of

subparagraph (A) and any factors under subparagraph (A)(iii).

''(3) The term 'geriatric assessment eligible individual' shall not include the following individuals:

''(A) An individual who is receiving hospice care under this title.

''(B) An individual who is residing in a skilled nursing facility, a nursing facility (as defined in section 1919), or any other facility identified by the Secretary.

''(C) An individual medically determined to have end-stage renal disease.

''(D) An individual enrolled in a Medicare Advantage plan or a plan under section 1876.

''(E) An individual enrolled in a PACE program under section 1894.

''(F) Any other categories of individuals determined appropriate by the Secretary.

''(4) For purposes of this subsection, the term 'chronic condition' means a condition, such as dementia, that lasts or is expected to last 1 year or longer, limits what an individual can do, and requires ongoing care.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

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

(A) in subparagraph (N), by inserting ''other than geriatric assessments (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

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

(2) PAYMENT.—

(A) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(o) PAYMENT FOR GERIATRIC ASSESSMENTS.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish—

''(i) a payment code (or codes) under this section for a geriatric assessment (as defined in section 1861(hhh)(1)) furnished to a geriatric assessment eligible individual (as defined in section 1861(iii)) by a physician, practitioner, or other provider described in section 1861(hhh)(2); and

''(ii) a payment amount for each such code.

''(B) REQUIREMENTS.—In establishing payment amounts under subparagraph (A)(ii), the Secretary shall—

''(i) take into account—

''(I) the amount of work required to perform a geriatric assessment, including the time and effort put forth by each qualified health care professional involved in performing the geriatric assessment; and

''(II) all of the costs associated with the geriatric assessment, including labor, supplies, equipment, and the costs of health information technologies and systems incurred by the physician, practitioner, or other pro-

vider (as described in section 1861(hhh)(2)) in providing the assessment; and

"(ii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

"(2) SEPARATE PAYMENTS FROM PAYMENTS FOR CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—Payments for geriatric assessments shall be made separately from payments for chronic care management and coordination services (as defined in section 1861(jjj)(1)) and other services for which payment is made under this title.".

(B) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 3(c)(2), is amended by inserting "(2)(FF)," after "(2)(EE),".

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is

amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or geriatric assessments (as defined in section 1861(hhh)(1))''.

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

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

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

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

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

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not

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

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

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

''(P) in the case of geriatric assessments (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

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

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

service is a geriatric assessment (as defined in section 1861(hhh)(1)) and furnished by a physician.''.

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amendments made by, and the provisions of, this section, including the establishment of additional domains under subsection (hhh)(1)(A)(iv) of section 1861 of the Social Security Act, as added by subsection (b). In promulgating such regulations, the Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations representing individuals with chronic conditions and older adults.

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

SEC. 4. MEDICARE COVERAGE OF CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.

(a) PART B COVERAGE OF CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—

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

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by adding ''and'' at the end; and

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

''(GG) chronic care management and coordination services (as defined in subsection (jjj));''.

(2) CONFORMING AMENDMENTS.—(A) Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)), as amended by section 3(a)(2), are each amended by striking ''subsections (ww)(1) and (hhh)(1)'' and inserting ''subsections (ww)(1), (hhh)(1), and (jjj)(1)''.

(B) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)), as amended by section 3(d), is amended by striking ''section 1861(s)(10)'' and inserting ''paragraphs (2)(GG) and (10) of section 1861(s)''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 3(b), is amended by adding at the end the following new subsection:

''Chronic Care Management and Coordination Services; Chronic Care Manager; Chronic Care Eligible Individual

''(jjj)(1) The term 'chronic care management and coordination services' means services that are furnished to a chronic care eligible individual (as defined in paragraph (3)) by, or under the supervision of, a single chronic care manager (as defined in paragraph (2)) chosen by the chronic care eligible individual, a caregiver designated by the individual in writing, or a representative authorized to make decisions on the individual's behalf, under a plan of care prescribed by such chronic care manager for the purpose of chronic care coordination, including dementia as appropriate, which may include any of the following services:

''(A) The development of an initial plan of care (based on the results of a geriatric assessment, as defined in subsection (hhh)), and subsequent appropriate revisions to that plan of care.

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

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

''(D) Patient education and counseling services.

''(E) Family caregiver education and counseling services, including preventive care consistent with the patient's condition.

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

''(G) Providing access for individuals, and caregivers or authorized representatives as appropriate, by telephone and email to physicians or other appropriate health care professionals, including 24-hour availability of such professionals for after hours consultation.

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

''(I) Managing and facilitating transitions that occur 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.

''(J) Information about pain management and palliative care.

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

''(L) Information about, referral to, and coordination with, community resources.

''(M) Such additional services for which payment would not otherwise be made under this title that the Secretary may specify that encourage the receipt of, or improve the effectiveness of, the services described in the preceding subparagraphs.

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

''(i) is—

''(I) a physician;

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

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

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

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

''(I) the physician, practitioner, or other provider who completed the geriatric assessment of the individual; or

''(II) a physician, practitioner, or other provider to whom the individual's care was transferred by the physician, practitioner, or other provider who performed the geriatric assessment.

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

''(I) subject to clause (ii), be entered into for a period of 3 years and may be renewed if the Secretary is satisfied that the chronic care manager continues to meet such terms and conditions as the Secretary may require; and

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

''(ii) Each chronic care management and coordination agreement shall provide for the termination of such agreement prior to such 3-year period in the case where the chronic care manager—

''(I) is no longer able to provide chronic care services; or

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

''(C)(i) Subject to clause (ii), the requirements of this subparagraph are met if the agreement requires the chronic care manager to perform, or provide for the performance of, the following services:

''(I) Advocating for, and providing ongoing support, oversight, and guidance with respect to the implementation of a plan of care that provides an integrated, coherent, and cross-disciplined plan for ongoing medical care that is developed in partnership with the chronic care eligible individual and all other physicians and other care providers and agencies (including home health agencies) providing care to the chronic care eligible individual.

''(II) Using evidence-based medicine and clinical decision support tools to guide decision making at the point of care and on the basis of specific patient factors.

''(III) Using health information technology, including, where appropriate, remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

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

''(V) Incorporating family caregivers into the chronic care planning process.

''(ii) The Secretary may modify the services required under the agreement under clause (i), including by requiring different services or services in addition to those described in subclauses (I) through (V) of such clause.

''(D) The Secretary shall adopt procedures which exempt providers in rural areas from providing 1 or more of the services otherwise required to be provided under subparagraph (C) or modify such requirements for such providers. In establishing such procedures, the Secretary shall ensure that such exemptions and modifications do not impact the quality of chronic care management and coordination services furnished by such providers.

''(3) For purposes of this subsection, the term 'chronic care eligible individual' means a geriatric assessment eligible individual (as defined in subsection (iii)) who has undergone a geriatric assessment (as defined in subsection (hhh)(1)) which determined that the individual would benefit from chronic care management and coordination.

''(4) Chronic care management and coordination services may be furnished in the chronic care eligible individual's home or residence.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

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

(A) in subparagraph (N), by inserting ''or chronic care management and coordination services (as defined in section 1861(jjj)(1))'' after ''other than geriatric assessments (as defined in section 1861(hhh)(1))'';

(B) by striking ''and'' before ''(X)''; and

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

(2) PAYMENT.—

(A) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as

amended by section 3(c)(2), is amended by adding at the end the following new subsection:

"(p) PAYMENT FOR CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish—

"(i) a payment code (or codes) under this section for chronic care management and coordination services (as defined in paragraph (1) of section 1861(jjj)) furnished to a chronic care eligible individual (as defined in paragraph (3) of such section) by a chronic care manager (as defined in paragraph (2) of such section); and

"(ii) a payment amount for each such code.

"(B) REQUIREMENTS.—In establishing payment amounts under subparagraph (A)(ii), the Secretary shall—

"(i) take into account—

"(I) the amount of work required of the chronic care manager in providing chronic care management and

coordination services to eligible individuals; and

''(II) all of the costs associated with providing chronic care management and coordination services, including labor, supplies, equipment, and the costs of health information technologies and systems incurred by the chronic care manager in providing such services;

''(ii) ensure that such payments are for such services furnished during a 30-day period; and

''(iii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

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

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

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 3(c)(3)(A), is amended by striking ''or geriatric assessments (as defined in section 1861(hhh)(1))'' and inserting ''geriatric assessments (as defined in section 1861(hhh)(1)), or chronic care management and coordination services (as defined in section 1861(jjj)(1))''.

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

(i) in subparagraph (G)(ii), by striking ''and'' at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

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

''(I) with respect to chronic care management and coordination services (as defined in section 1861(jjj)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(Y),''.

(4) ELIMINATION OF DEDUCTIBLE.—Paragraph (10) of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as added by section 3(c)(4), is amended by inserting ''or chronic care management and coordination services (as defined in section 1861(jjj)(1))'' after ''geriatric assessments (as defined in section 1861(hhh)(1))''.

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

''(6) GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—In the case of a designated health service, if the designated health service is—

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

"(B) furnished by a physician.".

(e) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amendments made by, and the provisions of, this section. In promulgating such regulations, the Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations, and organizations representing individuals with chronic conditions and older adults.

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

SEC. 5. OUTREACH ACTIVITIES REGARDING GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

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

ble to receive coverage of geriatric assessments (as defined in subsection (hhh)(1) of section 1861 of the Social Security Act, as added by section 3) under the Medicare program and individuals likely to be eligible to receive coverage of chronic care management and coordination services (as defined in subsection (jjj)(1) of such section 1861, as added by section 4) under the Medicare program, to inform such individuals about the availability of such benefits under the Medicare program.

SEC. 6. UTILIZATION OF TELEHEALTH SERVICES TO FURNISH GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

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

"(iii) GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—The term 'telehealth service' shall also include geriatric assessments (as defined in section 1861(hhh)(1)) and chronic care management and coordination services (as defined in section 1861(jjj)).".

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

SEC. 7. STUDY AND REPORT ON GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with an entity to conduct a study on—

(1) the effectiveness of the coverage of geriatric assessments and chronic care management and coordination services, including an evaluation of the use of interdisciplinary teams in providing such services, under the Medicare program (under the amendments made by sections 3 and 4) on improving the quality of care provided to Medicare beneficiaries with chronic conditions, including dementia; and

(2) the impact of such geriatric assessments and care coordination services on reducing expenditures under title XVIII of the Social Security Act, including reduced expenditures that may result from—

(A) reducing preventable hospital admissions;

(B) more appropriate use of pharmaceuticals; and

(C) reducing duplicate or unnecessary tests.

(b) REPORT.—Not later than 3 years after the date of enactment of this Act, the entity conducting the study under subsection (a) shall submit to Congress and the Secretary of Health and Human Services a report on the study, together with recommendations for such legislation or administrative action as such entity determines appropriate.

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

SEC. 8. RULE OF CONSTRUCTION.

Nothing in the provisions of, or in the amendments made by, this Act shall be construed as requiring an individual to receive a geriatric assessment (as defined in section 1861(hhh)(1) of the Social Security Act, as added by section 3(b)) or chronic care management and coordination services (as defined in section 1861(jjj)(1) of such Act, as added by section 4(b)).

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