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107TH CONGRESS
1ST SESSION

H. R. 2953

To amend title XVIII of the Social Security Act to make the social health maintenance organization a permanent option under the Medicare+Choice program.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 25, 2001

Mr. HORN introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to make the social health maintenance organization a permanent option under the Medicare+Choice 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 ''Medicare Coordinated Community Care Act of 2001''.

SEC. 2. MAKING SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (S/HMOS) A PERMANENT OPTION AS COORDINATED COMMUNITY CARE PLANS UNDER THE MEDICARE+CHOICE PROGRAM.

(a) INCLUSION OF COORDINATED COMMUNITY CARE PLANS INTO GROUPING OF MEDICARE+CHOICE COORDINATED CARE PLANS.—Section 1851(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(A)) is amended by striking ''and preferred provider organization plans'' and inserting ''preferred provider organization plans, and coordinated community care plans (as defined in section 1859(b)(4))''.

(b) DEFINITION OF COORDINATED COMMUNITY CARE PLAN.—Section 1859(b) of such Act (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

''(4) COORDINATED COMMUNITY CARE PLAN.—The term 'coordinated community care plan' means a Medicare+Choice plan that (in addition to providing services and otherwise meeting the requirements of this part) meets the following requirements:

''(A) The plan provides as benefits to all enrollees chronic illness services and ancillary services, as specified in section 1852(a)(6).

''(B) The plan provides as benefits expanded care services, as specified in section 1852(a)(7), to enrollees who meet the criteria for at-risk enrollees (as defined in paragraph (5)).

''(C) The plan meets the quality assurance requirements specified in section 1852(e)(2)(E).

''(D) The plan submits to the Secretary reports on the functional status of enrollees as well as on expenditures and utilization of covered expanded care services.

''(5) AT-RISK ENROLLEE.—For purposes of determining an enrollee's eligibility to receive expanded care services from a coordinated community care plan, the term 'at-risk enrollee' means an enrollee of a coordinated community care plan who has been determined by the coordinated community care plan, based on a multidimensional, geriatric assessment, to meet at least one of the following criteria:

''(A) The individual needs personal supervision or hands-on assistance with bathing, dressing, transferring, toileting, eating, or daily mobility assistance inside the home.

''(B) The individual needs protection and supervision on a constant basis due to cognitive impairment.

''(C) The individual needs daily personal assistance to ensure proper administration and management of prescribed medications or medical or nursing procedures.

''(D) The individual needs personal assistance (at least 3 times a week) to manage incontinence problems or ostomy equipment.

''(E) The individual needs special ongoing management because the enrollee is frequently disruptive, aggressive, or agitated, or is a danger to self or others.

''(F) The individual needs help to prevent, delay, or minimize functional decline.

''(G) The individual meets such other criteria as the Secretary may determine.''.

(c) INFORMATION ON BENEFITS.—Section 1851(a)(4)(A) of such Act (42 U.S.C. 1395w–21(a)(4)(A)) is amended by adding at the end the following new clause:

''(ix) In the case of a coordinated community care plan, differences in benefits, care coordination services, quality im-

provement programs, and other distinguishing factors compared to other Medicare+Choice plans.''.

(d) BASIC AND EXPANDED BENEFITS.—Section 1852 of such Act (42 U.S.C. 1395w–22) is amended—

(1) by adding at the end of subsection (a) the following new paragraphs:

''(6) BENEFITS OFFERED BY COORDINATED COMMUNITY CARE PLANS.—

''(A) IN GENERAL.—In addition to the benefits required under parts A and B, each coordinated community care plan shall make available to each enrollee—

''(i) chronic illness care services (described in subparagraph (B)) to manage common geriatric conditions and chronic illness; and

''(ii) ancillary services described in subparagraph (C).

''(B) CHRONIC ILLNESS CARE SERVICES.—Chronic illness care services under this subparagraph shall be furnished in accordance with guidelines and protocols adopted by the Secretary and by geriatricians, geriatric nurse practitioners, and other providers experienced

in chronic illness care. Such services may include geriatric and chronic illness and disability training supplements, consultation with medical specialists, and other services deemed appropriate by the plans.

''(C) ANCILLARY SERVICES.—Ancillary services under this subparagraph—

''(i) shall include prescription drugs, eyeglasses, and hearing aids, in an amount and duration specified under the plan; and

''(ii) may also include, at the discretion of the plan, such preventive services and other items and services not otherwise covered under part A or B as the plan may specify.

''(7) EXPANDED CARE SERVICES FOR AT-RISK ENROLLEES.—

''(A) IN GENERAL.—In addition to the benefits required under parts A and B and paragraph (6), each coordinated community care plan shall make available to each at-risk enrollee (as defined in section 1859(b)(5)) through providers with appropriate expertise in geriatric and chronic illness care services and in

accordance with an expanded care plan under subsection (m)(3)—

"(i) benefits for home and community-based services described in subparagraph (B);

"(ii) benefits for supplemental non-acute institutional services described in subparagraph (C) but only in the case of an individual who does not reside in an institutional setting; and

"(iii) end-of-life and palliative care services described in subparagraph (D).

"(B) HOME AND COMMUNITY-BASED BENEFITS.—

"(i) IN GENERAL.—The home and community-based services under this subparagraph include, subject to clause (ii), personal care, homemakers, medical transportation, adult day health, and medication management. Such services may also include routine foot care in the home, home modifications, medical and adaptive equipment and supplies, expanded mental health services, personal emergency response sys-

tems, home-delivered meals, and nutritional assessments and services.

''(ii) SCOPE.—The benefits under this subparagraph may be limited to a specified dollar amount of coverage per enrollee per year (exclusive of member copayments). Such dollar limit—

''(I) for benefits during 2002, shall not be less than $7,500; or

''(II) for benefits during a subsequent year, shall not be less than the dollar amount specified under this clause for the previous year increased by minimum percentage increase in Medicare+Choice capitation rates provided under section 1853(c)(1)(C) applicable to that subsequent year.

''(iii) LIMITS ON COPAYMENTS.—With respect to the benefits under this subparagraph, a coordinated community care plan may not charge a deductible and may not charge copayments that exceed 25 percent.

''(C) SUPPLEMENTAL NON-ACUTE INSTITUTIONAL SERVICES.—

"(i) IN GENERAL.—Benefits for supplemental non-acute institutional services under this subparagraph are benefits for institutional care (such as care in an institutional setting, as defined in clause (iv)) that is not otherwise covered under part A or part B and that is in aid of returning the enrollee to a community residence and that is provided to an individual who resides outside an institutional setting.

"(ii) DURATION.—

"(I) INITIAL PERIOD OF ELIGIBILITY.—The benefits under this subparagraph shall include at least 14 days of supplemental non-acute institutional care.

"(II) SUBSEQUENT PERIODS OF ELIGIBILITY.—After receipt of the benefits described in subclause (I), after the at-risk enrollee has resumed residing in a community residence for a continuous period of 60 days, subject to subclause (III), the benefits under this subparagraph shall include

at least an additional 14 days of supplemental non-acute institutional care.

"(III) ANNUAL LIMITATION.—A plan is not required to provide supplemental non-acute institutional care for more than 30 days of supplemental non-acute institutional care for any enrollee in any calendar year.

"(IV) COMMUNITY RESIDENCE.—For purposes of this clause, the term 'community residence' means a residence in a community-setting and does not include a residence in any institutional setting.

"(iii) LIMITS ON COPAYMENTS.—With respect to the supplemental non-acute institutional services benefit under this subparagraph, the coordinated community care plan may not charge a deductible and may not charge copayments that exceed 25 percent.

"(iv) INSTITUTIONAL SETTING.—For purposes of this paragraph, the term 'institutional setting' includes a nursing facility,

assisted living facility, adult foster home, or other licensed non-acute care facility.

''(D) END-OF-LIFE CARE.—End-of-life and palliative care services under this subparagraph shall not be limited to the last 6 months of life, shall cover a broader range of life-limiting conditions than traditional hospice care, and shall include support of family caregivers.''; and

(2) by adding at the end the following new subsection:

''(m) CARE COORDINATION.—Coordinated community care plans shall adopt a care coordination program for serving members. This program shall include geriatric-focused assessment and care planning that meet at least the following requirements:

''(1) POPULATION SCREENING.—The coordinated community care plan shall screen each new enrollee upon enrollment and annually thereafter through a self-report health status form with a standardized set of core items designed to identify enrollees who may be at risk due to medical, psychological, behavioral, environmental, or functional conditions.

''(2) CLINICAL SCREENING.—In the case of an enrollee who is identified, under a screening under

paragraph (1) or otherwise, as potentially being at risk due to conditions described in such paragraph or who otherwise self-identifies as potentially being so at risk, the coordinated community care plan shall provide for an appropriate clinical screening to determine if the enrollee is an at-risk enrollee.

''(3) COMPREHENSIVE ASSESSMENT AND PLANNING.—In the case of an enrollee identified as an at-risk enrollee, a care coordinator in the coordinated community care plan shall contact the enrollee to determine the enrollee's need for a comprehensive assessment to determine the enrollee's needs, preferences, and eligibility for expanded care benefits. Such an assessment shall be conducted in the enrollee's home and other settings, as appropriate, using flexible, multidimensional geriatric approaches that incorporate medical, functional, psychological, and environmental dimensions. All at-risk enrollees shall be assigned a care coordinator who will develop an expanded care plan based on the multidimensional assessment, information on medical status and care, and member preferences. The coordinated community care plan shall assure that at-risk enrollees be referred in a timely manner to the appropriate pro-

vider or providers for appropriate services under the expanded care plan.

''(4) INTEGRATION OF CARE.—Procedures shall be established among such care coordinators and acute and expanded care providers in such plans to ensure timely sharing of clinical information, assignment of responsibility, and coordination and integration of services under the expanded care plan across all providers and settings in a manner that meets the special needs of geriatric and chronically ill or impaired individuals.''.

(d) QUALITY ASSURANCE.—Section 1852(e)(2) of such Act (42 U.S.C. 1395w–22(e)(2)) is amended by adding at the end the following new subparagraph:

''(E) COORDINATED COMMUNITY CARE PLANS.—In addition in the case of a coordinated community care plan, the quality assurance program shall employ systems to ensure the quality of covered expanded care and chronic illness care services. The Secretary shall establish appropriate outcome measures for assessing the quality of care provided to frail elderly and at-risk enrollees with chronic conditions in such plans. Such outcome indicators

shall measure plans' and providers' effectiveness in—

''(i) integrating the delivery of acute care and expanded care;

''(ii) meeting identified expanded care needs;

''(iii) preventing, delaying, or minimizing disability progression; and

''(iv) preventing or delaying institutionalization.''.

(e) PAYMENTS.—Section 1853 of such Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) COORDINATED COMMUNITY CARE PLANS.—Notwithstanding the previous provisions of this section, each coordinated community care plans shall be paid under this section as follows:

''(1) IN GENERAL.—Except as provided in paragraph (2)—

''(A) CURRENT SOCIAL HMOS.—In the case of a coordinated community care plan that contracted with the Secretary to furnish services as a social HMO during 2001 and that continues to contract with the Secretary following the effective date of this subsection, payment shall be

based on the same risk adjustment factors and formula such plan was paid during 2001.

''(B) OTHER PLANS.—In the case of a coordinated community care plan not described in subparagraph (A), before the adoption and implementation of a new payment methodology for coordinated community care plans under paragraph (2), the Secretary shall have the discretion to select one of the 2 methodologies for risk adjustment factors and formula that may be applied under subparagraph (A) to pay any Medicare+Choice coordinated care plan that is certified as a coordinated community care plan.

''(2) NEW PAYMENT METHODOLOGY.—The Secretary shall develop a new payment methodology to pay coordinated community care plans. In developing this new payment methodology, the Secretary shall be guided by the following 3 factors:

''(A) Recognizing that impairment-related costs are not adequately accounted for in the individual diagnostic and demographic factors used to adjust payments for other Medicare+Choice plans, a functional status factor or factors or other factors equally sensitive to costs associated with disability, frailty, and

comorbidities will be included in the coordinated community care plan payment system.

''(B) There will be an enhancement of the underlying base payment to coordinated community care plans that reflects the increased risk of offering the additional benefits required by paragraphs (6) and (7) of section 1852(a). The Secretary shall make this enhancement commensurate with the original intent of the Deficit Reduction Act of 1984 to pay not less than the actuarial equivalent of 100 percent of what would have been paid under this title for the enrolled members had they not enrolled in a plan under this part but obtained benefits through the fee-for-service system.

''(C) The Secretary shall assure that the payment methodology will not change because a coordinated community care plan has a contract with a State under title XIX to serve individuals dually eligible under this title and that title.

''(3) TRANSITION.—If the payment methodology developed by the Secretary under paragraph (2) results in a reduction of payment to a coordinated community care plan that is receiving pay-

ment under a method described in paragraph (1), the Secretary shall establish a 4-year transition period during which the new payment methodology is phased in. During the first year of the transition, payment will be based on a blend weighted ¼ of the new payment methodology under paragraph (2) and ¾ of the payment methodology under paragraph (1). During each of the second and third years, payment will be based on a blend weighted ½ and ¾, respectively, of the new payment methodology under paragraph (2) and ½ and ¼, respectively, based on the payment methodology under paragraph (1). The Secretary shall fully implement the new payment methodology during the fourth year.

''(4) COMMENT.—The Secretary shall submit the new payment methodology for coordinated community care plans to public comment as part of the advance notice of methodological changes under section 1853(b)(2).''.

(f) PREMIUMS.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new subparagraph:

''(F) SPECIAL RULES FOR COORDINATED COMMUNITY CARE PLANS.—

''(i) Each coordinated community care plan shall include as additional benefits those services described in paragraphs (6) and (7) of section 1852(a) unless inclusion of the additional benefits results in the actuarial value of the benefits exceeding the average of the capitation payments made to the coordinated community care plan. If so, the coordinated community care plan may treat the excess as a supplemental benefit (as defined in section 1852(a)(3)), and charge a premium for the actuarial value of the excess costs.

''(ii) Nothing in this part shall be construed to preclude a coordinated community care plan from furnishing the services specified in section 1852(a)(7) only to at-risk enrollees (as defined in section 1859(b)(5)).''.

(g) DISCRETION TO WAIVE REQUIREMENTS.—Section 1856(b) of such Act (42 U.S.C. 1395w–26(b)) is amended by adding at the end the following new paragraph:

''(4) ADAPTATION TO COORDINATED COMMUNITY CARE PLANS.—In establishing standards under

this section, the Secretary shall adapt such standards as they apply to coordinated community care plans to appropriately account for their unique characteristics as reflected in the composition of enrollment and the care coordination and expanded benefit requirements under this part.''.

(h) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on January 1, 2002.

(2) TRANSITION.—

(A) IN GENERAL.—Upon the enactment of this section, the Secretary of Health and Human Services shall proceed in an expedited manner to develop and promulgate the necessary rules and the payment methodology required by the amendments made by this section.

(B) APPLICATION OF REQUIREMENTS.—Except as provided in paragraph (3), the Secretary of Health and Human Services may not certify a Medicare+Choice organization as meeting the requirements applicable to coordinated community care plans under part C of title XVIII of the Social Security Act until the

adoption of final regulations implementing the statutory requirements applicable to coordinated community care plans under such part.

(3) DEEMED TREATMENT.—

(A) CURRENT S/HMOS.—Any Medicare+Choice organization that is operating as of the date of the enactment of this Act under demonstration authority as a Social HMO (S/HMO I or S/HMO II or a combination thereof) shall be deemed to meet the requirements applicable to coordinated community care plans under part C of title XVIII of the Social Security Act from the effective date specified in paragraph (1) through 24 months following the date the Secretary publishes final regulations establishing standards for coordinated community care plans under the amendments made by this section.

(B) S/HMOS WITH PLANNING GRANTS.—In the case of an entity that received a planning grant in 1998 under the 1997 Grants Program for Reforming Service Delivery for Dual Eligible Beneficiaries to develop a Second Generation Social HMO Demonstration program, if the Secretary determines that the program de-

veloped under such a grant would qualify to operate as a demonstration authority as a Social HMO (S/HMO I or S/HMO II or a combination thereof), the Secretary may treat the entity with respect to such program as a Social HMO for purposes of applying subparagraph, effective on a date specified by the Secretary.

(4) IMMEDIATE REMOVAL OF LIMITATION ON NUMBER OF MEMBERS PER SITE UNDER DEMONSTRATION PROJECT.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993, as amended by sections 4014(b) of the Balanced Budget Act of 1997 and by section 531(c) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 1501A–388), is amended—

(A) in the heading, by striking ''AGGREGATE'' and inserting ''NO''; and

(B) by striking ''other than an aggregate limit of not less than 324,000 for all sites''.

(5) LIMITATION ON INITIAL EXPANSION.—In the first 3 years following the effective date of implementing regulations described in paragraph (2)(A), the Secretary of Health and Human Services shall not approve any more than the following total num-

ber of coordinated community care plans under part C of title XVIII of the Social Security Act (in addition to the plans referred to in paragraph (3)):

(A) In the first such year, 5 coordinated community care plans.

(B) In the second such year, 15 coordinated community care plans.

(C) In the third such year, 30 coordinated community care plans.

For any succeeding year, there shall be no limit on the number of such plans that may be approved.

(i) ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Advisory Committee on Social HMO Replication to assist Medicare+Choice plans, health care providers, and other appropriate organizations in the design, implementation, and ongoing evaluation of coordinated community care plans under the amendments made by this section.

(2) MEMBERSHIP.—Membership on the committee shall include representation from the following:

(A) Existing Social HMO I and II sites.

(B) Social HMO II planning grant sites.

(C) Providers and professionals with expertise in geriatric medicine, chronic illness care and home and community-based service programs.

(D) Representatives from the Federal and State governments with oversight responsibilities for programs serving the elderly and disabled.

(E) Representatives from the Social HMO research and development groups at Brandeis University, University of Minnesota, and the University of California at San Francisco.

(F) Such other representatives as the Secretary may designate.

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