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107TH CONGRESS
1ST SESSION

# H. R. 3027

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

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IN THE HOUSE OF REPRESENTATIVES

OCTOBER 4, 2001

Mr. GREEN of Texas introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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 permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the Medicare Program.

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

**SECTION 1. SHORT TITLE.**

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

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

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

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

rural health clinic's, or Federally qualified health center's most recent cost reporting period ending before the date that is 6 months after the date of enactment of such Act.''.

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

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

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

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

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

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

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

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

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

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

''(ww)(1) The term 'care coordination and assessment services' means services that are furnished to an individual with a serious and disabling chronic condition (as defined in paragraph (2)) by a care coordinator (as defined in paragraph (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

''(A) An initial assessment of an individual's medical condition, functional and cognitive capacity, and environmental and psychological needs and an annual reassessment of such condition, capacity, and needs, unless the care coordinator determines that a more frequent reassessment is necessary based on sentinel health events (as defined by the Secretary) or a change in health status that may require a change in the individual's plan of care.

''(B) The coordination of, and referral for, medical and other health services, including—

''(i) multidisciplinary care conferences;

''(ii) coordination with other providers (including telephone consultations with physicians); and

''(iii) the monitoring and management of medications, with special emphasis on the management on behalf of an individual with a serious and disabling chronic condition that uses multiple medications (including coordination with the entity managing benefits for the individual).

''(C) Patient and family caregiver education and counseling services (through office visits or telephone consultation), including self-management serv-

ices and risk appraisal services to identify behavioral risk factors through self-assessment.

''(D) Such other services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate, including activities to facilitate continuity of care and patient adherence to plans of care.

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

''(A) is unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as described in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) for a period of at least 90 days due to a loss of functional capacity;

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

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

''(D) requires substantial supervision to protect such individual from threats to health and safety due to a severe cognitive impairment (as defined by the Secretary).

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

''(i) is—

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

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

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

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

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

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

''(ii) assure that the care coordinator will submit reports to the Secretary on the functional and medical status of individuals with a chronic and disabling condition who receive care coordination services, expenditures relating to such services, and health outcomes relating to such services, except that the Secretary may not require a care coordinator to submit more than 1 such report during a year; and

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

(c) PAYMENT AND ELIMINATION OF COINSURANCE.—

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

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

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to care coordination and assessment services described in section 1861(s)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service''.

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

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

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by section 105(d) of the

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–472), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by adding at the end the following new clause:

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

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

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

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

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

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

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

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms and establish

such procedures as the Secretary determines necessary to implement the provisions of this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to care coordination and assessment services furnished on or after January 1, 2003.

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