I

108TH CONGRESS
2D SESSION

H. R. 4689

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 2004

Mr. GREEN of Texas (for himself, Mr. HINCHEY, Mr. RANGEL, Mr. FROST, Mr. GUTIERREZ, and Mr. ENGEL) 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 provide Medicare beneficiaries with access to geriatric assessments and chronic care management, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Geriatric and Chronic Care Management Act of 2004".

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) We must redesign the medicare system to provide high-quality, cost-effective care to a growing population: elderly individuals with multiple chronic conditions.

(2) According to the Congressional Budget Office, 50 percent of medicare costs can be attributed to 5 percent of medicare's most costly beneficiaries.

(3) Currently, 82 percent of the medicare population has at least 1 chronic condition, and ⅔ have more than 1 chronic condition. The 20 percent of beneficiaries with 5 or more chronic conditions account for ⅔ of all medicare spending. In addition, the large Baby Boomer generation is moving toward retirement and medicare eligibility.

(4) In general, the prevalence of chronic conditions increases with age: 74 percent of the 65- to 69-year-old group have a least 1 chronic condition, while 86 percent of the 85 years and older group

have at least 1 chronic condition. Similarly, just 14 percent of the 65- to 69-year-olds have 5 or more chronic conditions, but 28 percent of the 85 years and older group have 5 or more chronic conditions.

(5) There is a strong pattern of increasing utilization as the number of conditions increase. Fifty-five percent of medicare beneficiaries with 5 or more conditions experienced an inpatient hospital stay compared to 5 percent for those with 1 condition or 9 percent for those with 2 conditions.

(6) In terms of physician visits, the average medicare beneficiary has over 15 physician visits annually and sees 6 different physicians annually.

(7) There is almost a 4-fold increase in visits by people with 5 chronic conditions compared to visits by people with 1 chronic condition. The number of specific physicians seen increases almost 2½ times for people with 5 or more chronic conditions relative to those with just 1 chronic condition.

(8) When Alzheimer's disease and dementia are present along with 1 or more other chronic conditions, utilization also increases. For example, in 2000, total average per person medicare expenditures for those with congestive heart failure and Alzheimer's or dementia were 47 percent higher than

for those with congestive heart failure and no dementia.

(9) Based on numerous studies in the United States and internationally, we know that the delivery of higher quality health care, increased efficiency and cost-effectiveness are the result of systems in which patients are linked with a physician or other qualified health professional who coordinates their care.

(10) The current medicare program penalizes physicians for integrating and coordinating health care because these services are not explicitly recognized and distinctly paid for. Instead, physicians are incentivized to provide episodic care and to generate more individual patient visits to the doctor's office and hospital for separately reimbursed tests and procedures.

(11) The chronic care model established by this Act includes several elements that are effective in managing chronic disease—

(A) linkages with community resources;

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

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

(D) practice redesign;

(E) evidence-based clinical practice guidelines; and

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

(12) We must realign the financial incentives within medicare as part of a comprehensive system change. Medicare should be restructured to reimburse physicians and other qualified health professionals for the cost of coordinating care.

SEC. 3. MEDICARE COVERAGE OF GERIATRIC ASSESSMENTS.

(a) PART B COVERAGE OF GERIATRIC ASSESSMENTS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 642(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2322), is amended—

(A) in subparagraph (Y), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (Z), by adding ''and'' after the semicolon at the end; and

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

''(AA) geriatric assessments (as defined in subsection (bbb)(1)).''.

(2) CONFORMING AMENDMENTS.—(A) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)), as amended by section 611(d)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2304), is amended by striking ''or (K)'' and inserting ''(K), or (AA)''.

(B) 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 611(d)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2304), are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (bbb)(1)''.

(b) GERIATRIC ASSESSMENTS DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 706(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2339), is amended by adding at the end the following new subsection:

''Geriatric Assessment; Eligible Individual

''(bbb)(1) The term 'geriatric assessment' means—

''(A) an initial assessment of an eligible individual's medical condition, functional and cognitive capacity, primary caregiver needs, and environmental and psychosocial needs that is conducted by a physician 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; and

''(B) subsequent assessments, which may not be conducted more frequently than annually, unless a physician or chronic care manager of the eligible individual determines that such assessments are required due to sentinel health events or changes in the health status of the individual that may require changes in plans of care developed for the individual.

''(2)(A) For purposes of this subsection, the term 'eligible individual' means an individual who has—

''(i) at least 5 chronic conditions and an inability to manage care (as defined by the Secretary); or

''(ii) a mental or cognitive impairment, including dementia, and at least 1 other chronic condition.

''(B) For purposes of this paragraph, the term 'chronic condition' means an illness, functional limitation, or cognitive impairment that is expected to last at least 1 year, limits the activities of an individual, 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)), as amended by section 302(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2229), is amended—

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

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

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

the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 611(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2304), is amended by inserting ''(2)(AA),'' after ''(2)(W),''.

(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 614 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2306), is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or geriatric assessments (as defined in section 1861(bbb)(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'' after the semicolon 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(bbb)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W),''.

(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 ''(6)''; and

(B) by inserting before the period the following: '', and (7) such deductible shall not apply with respect to geriatric assessments (as defined in section 1861(bbb)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 613(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2306), is amended—

(1) by striking ''and'' at the end of subparagraph (L);

(2) by striking the semicolon at the end of subparagraph (M) and inserting '', and''; and

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

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

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by section 101(e)(8)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2306), 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(bbb)(1)) and furnished by a physician.''.

(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 assessments and chronic care management services furnished on or after January 1, 2005.

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

(a) PART B COVERAGE OF CHRONIC CARE MANAGEMENT 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 (Z), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (AA), by adding ''and'' after the semicolon at the end; and

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

''(BB) chronic care management services (as defined in subsection (ccc));''.

(2) CONFORMING AMENDMENTS.—(A) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)), as amended section 3(a)(2)(A), is amended by striking ''or (AA)'' and inserting ''(AA), or (BB)''.

(B) 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)(B), are each amended by striking ''subsections (ww)(1) and (bbb)'' and inserting ''subsections (ww)(1), (bbb), and (ccc)''.

(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 Services; Chronic Care Manager; Eligible Individual

''(ccc)(1) The term 'chronic care management services' means services that are furnished to an eligible individual (as defined in paragraph (3)) by a chronic care manager (as defined in paragraph (2)) under a plan of care prescribed by such chronic care manager for the purpose of chronic care management, which may include any of the following services:

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

''(B) The management of, and referral for, medical and other health services, including multi-

disciplinary 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.

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

''(G) Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergency consultations.

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

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

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

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

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

''(K) Information about, referral to, and management with, community services.

''(L) 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 to 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 (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 chronic care management agreement with the Secretary; and

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

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

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

''(ii) ensure that the chronic care manager will submit reports to the Secretary on the functional and medical status of eligible individuals who receive chronic care management services, expenditures relating to such services, and health outcomes relating to such services, except that the Secretary may not require a chronic care manager to submit more than one such report during a year; and

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

''(3) For purposes of this subsection, the term 'eligible individual' means an eligible individual (as defined in subsection (bbb)(2)) who has undergone a geriatric assess-

ment (as defined in subsection (bbb)(1)) and who a physician has determined would benefit from chronic care management.''.

(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 services (as defined in section 1861(ccc))'' after ''other than geriatric assessments (as defined in section 1861(bbb)(1))'';

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

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to chronic care management services (as defined in section 1861(ccc)), the amount paid shall be 100 percent of the amount determined under section 1834(n)''.

(2) PAYMENT.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) PAYMENT FOR CHRONIC CARE MANAGEMENT SERVICES.—

"(1) IN GENERAL.—The Secretary shall pay for chronic care management services (as defined in section 1861(ccc)(1)) furnished to an eligible individual (as defined in section 1861(ccc)(3)) by a chronic care manager (as defined in section 1861(ccc)(2))—

"(A) separately from geriatric assessments (as defined in section 1861(bbb)(1)) and other services for which payment is made under this title; and

"(B) based on the methodology selected by the chronic care manager (as so defined) from among the methodologies developed and implemented by the Secretary under paragraph (2).

"(2) DEVELOPMENT AND IMPLEMENTATION OF PAYMENT METHODOLOGIES.—The Secretary, in consultation with national membership associations representing physicians, qualified health professionals, and patients, shall develop and implement payment methodologies applicable with respect to chronic care management services (as defined in section 1861(ccc)(1)) as follows:

"(A) UNADJUSTED MONTHLY CAPITATED PAYMENT AMOUNT.—A per patient per month

chronic care management fee separate from evaluation and management services for which payment is made under the physician fee schedule under section 1848 that does not take into account the severity of the eligible individual's condition.

"(B) ADJUSTED MONTHLY CAPITATED PAYMENT AMOUNT.—A per patient per month chronic care management fee separate from evaluation and management services for which payment is made under the physician fee schedule under section 1848 that provides for an adjustment to the payment amount based on the severity of the eligible individual's condition.

"(C) UNADJUSTED FEE SCHEDULE AMOUNT.—A chronic care management fee for care coordination that includes payment for related evaluation and management services for which payment would otherwise be made under the physician fee schedule under section 1848 that does not take into account the severity of the eligible individual's condition.

"(D) ADJUSTED FEE SCHEDULE AMOUNT.—A chronic care management fee for care coordination that includes payment for re-

lated evaluation and management services for which payment would otherwise be made under the physician fee schedule under section 1848 that provides for an adjustment to the payment amount based on the severity of the eligible individual's condition.

''(E) OTHER PAYMENT METHODOLOGIES.—Any other payment methodology that the Secretary determines effective in creating incentives for physicians and other chronic care managers to make practice-based improvements to improve the quality and cost-effectiveness of care provided to eligible individuals.''.

(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(bbb)(1))'' and inserting ''geriatric assessments (as defined in section 1861(bbb)(1)), or chronic care management services (as defined in section 1861(ccc)(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 (G)(ii), by striking ''and'' after the semicolon 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 services (as defined in section 1861(ccc)(1)) furnished by an outpatient department of a hospital, the amount determined under section 1834(n),''.

(4) ELIMINATION OF DEDUCTIBLE.—Section 1833(b)(7) of the Social Security Act (42 U.S.C. 1395l(b)(7)), as added by section 3(c)(4), is amended by inserting ''or chronic care management services (as defined in section 1861(ccc)(1))'' after ''geriatric assessments (as defined in section 1861(bbb)(1))''.

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C.

1395u(b)(18)(C)) is amended by adding at the end the following new clause:

"(vii) A chronic care manager (as defined in section 1861(ccc)(2)) that is not a physician.".

(e) 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 SERVICES.—In the case of a designated health service, if the designated health service is—

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

"(B) provided by a physician or a chronic care manager (as defined in section 1861(ccc)(2)).".

(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 assessments and chronic care

management services furnished on or after January 1, 2005.

SEC. 5. STUDY AND REPORT ON BEST PRACTICES FOR MEDICARE CHRONIC CARE MANAGEMENT.

(a) STUDY.—The Secretary, in consultation with the Medicare Payment Advisory Commission, shall conduct a thorough study of the following issues:

(1) The effectiveness of the different payment methodologies applicable with respect to chronic care management services developed and implemented under section 1834(n)(2) of the Social Security Act (as added by section 4(c)(2)).

(2) The effectiveness of pay-for-performance programs to serve medicare beneficiaries with multiple chronic conditions, including dementia.

(3) Process measures and outcomes for medicare beneficiaries with multiple chronic illnesses, including dementia.

(4) The cost-effectiveness and quality associated with chronic care management under the medicare program.

(5) The feasibility of broadening and incorporating the findings of the Assessing Care of Vulnerable Elders (ACOVE) study into the medicare program.

(b) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) that contains—

(1) recommendations on the best practices for chronic care management of the conditions of medicare beneficiaries with multiple chronic conditions, including dementia; and

(2) such other recommendations for legislation or administrative action as the Secretary determines appropriate.

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