

108TH CONGRESS  
1ST SESSION

# S. 387

To amend title XVIII of the Social Security Act to extend the eligibility periods for geriatric graduate medical education, to permit the expansion of medical residency training programs in geriatric medicine, to provide for reimbursement of care coordination and assessment services provided under the medicare program, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

FEBRUARY 13, 2003

Mrs. LINCOLN (for herself, Mr. REID, Ms. SNOWE, Mr. BREAUX, Mr. GRAHAM of Florida, Mr. BINGAMAN, Ms. LANDRIEU, Mrs. MURRAY, Ms. MIKULSKI, Mr. SARBANES, Mr. REED, Mr. KENNEDY, 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 extend the eligibility periods for geriatric graduate medical education, to permit the expansion of medical residency training programs in geriatric medicine, to provide for reimbursement of care coordination and assessment services provided under the medicare program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the  
3 “Geriatric Care Act of 2003”.

4 (b) **TABLE OF CONTENTS.**—

Sec. 1. Short title; table of contents.

Sec. 2. Extension of eligibility periods for geriatric graduate medical education.

Sec. 3. Disregard of certain geriatric residents against graduate medical education limitations.

Sec. 4. Medicare coverage of care coordination and assessment services.

5 **SEC. 2. EXTENSION OF ELIGIBILITY PERIODS FOR GERI-**  
6 **ATRIC GRADUATE MEDICAL EDUCATION.**

7 (a) **DIRECT GME.**—Section 1886(h)(5)(G) of the So-  
8 cial Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amend-  
9 ed by adding at the end the following new clause:

10 “(vi) **GERIATRIC RESIDENCY AND**  
11 **FELLOWSHIP PROGRAMS.**—In the case of  
12 an individual enrolled in a geriatric resi-  
13 dency or fellowship program approved by  
14 the Secretary for purposes of subpara-  
15 graph (A), the period of board eligibility  
16 and the initial residency period shall be the  
17 period of board eligibility for the sub-  
18 specialty involved, plus 1 year.”.

19 (b) **CONFORMING AMENDMENT.**—Section  
20 1886(h)(5)(F) of the Social Security Act (42 U.S.C.  
21 1395ww(h)(5)(F)) is amended by striking “subparagraph  
22 (G)(v)” and inserting “clauses (v) and (vi) of subpara-  
23 graph (G)”.

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to cost reporting periods beginning  
 3 on or after the date that is 6 months after the date of  
 4 enactment of this Act.

5 **SEC. 3. DISREGARD OF CERTAIN GERIATRIC RESIDENTS**  
 6 **AGAINST GRADUATE MEDICAL EDUCATION**  
 7 **LIMITATIONS.**

8 (a) DIRECT GME.—Section 1886(h)(4)(F) of the So-  
 9 cial Security Act (42 U.S.C. 1395ww(h)(4)(F)) is amend-  
 10 ed by adding at the end the following new clause:

11 “(iii) INCREASE IN LIMITATION FOR  
 12 GERIATRIC FELLOWSHIPS.—For cost re-  
 13 porting periods beginning on or after the  
 14 date that is 6 months after the date of en-  
 15 actment of the Geriatric Care Act of 2003,  
 16 in applying the limitations regarding the  
 17 total number of full-time equivalent resi-  
 18 dents in the field of allopathic or osteo-  
 19 pathic medicine under clause (i) for a hos-  
 20 pital, rural health clinic, or Federally  
 21 qualified health center, the Secretary shall  
 22 not take into account a maximum of 3  
 23 residents enrolled in a fellowship or resi-  
 24 dency in geriatric medicine or geriatric  
 25 psychiatry within an approved medical

1           residency training program to the extent  
2           that the hospital, rural health clinic, or  
3           Federally qualified health center increases  
4           the number of such residents above the  
5           number of such residents for the hospital’s,  
6           rural health clinic’s, or Federally qualified  
7           health center’s most recent cost reporting  
8           period ending before the date that is 6  
9           months after the date of enactment of such  
10          Act.”.

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

14           “(ix) Clause (iii) of subsection (h)(4)(F), inso-  
15 far as such clause applies with respect to hospitals,  
16 shall apply to clause (v) in the same manner and for  
17 the same period as such clause (iii) applies to clause  
18 (i) of such subsection.”.

19 **SEC. 4. MEDICARE COVERAGE OF CARE COORDINATION**  
20 **AND ASSESSMENT SERVICES.**

21          (a) PART B COVERAGE OF CARE COORDINATION AND  
22 ASSESSMENT SERVICES.—Section 1861(s)(2) of the So-  
23 cial Security Act (42 U.S.C. 1395x(s)(2)) is amended—

24           (1) in subparagraph (U), by striking “and” at  
25          the end;

1           (2) in subparagraph (V)(iii), by adding “and”  
2           after the semicolon at the end; and

3           (3) by adding at the end the following new sub-  
4           paragraph:

5           “(W) care coordination and assessment services  
6           (as defined in subsection (ww)).”.

7           (b) CARE COORDINATION AND ASSESSMENT SERV-  
8           ICES DEFINED.—Section 1861 of the Social Security Act  
9           (42 U.S.C. 1395x) is amended by adding at the end the  
10          following new subsection:

11         “Care Coordination and Assessment Services; Individual  
12         With a Serious and Disabling Chronic Condition;  
13         Care Coordinator

14         “(ww)(1) The term ‘care coordination and assess-  
15         ment services’ means services that are furnished to an in-  
16         dividual with a serious and disabling chronic condition (as  
17         defined in paragraph (2)) by a care coordinator (as de-  
18         fined in paragraph (3)) under a plan of care prescribed  
19         by such care coordinator for the purpose of care coordina-  
20         tion and assessment, which may include any of the fol-  
21         lowing services:

22                 “(A)(i)(I) An initial assessment of an individ-  
23                 ual’s medical condition, functional and cognitive ca-  
24                 pacity, and environmental and psychosocial needs.

1           “(II) Annual assessments after the initial as-  
2           sessment performed under subclause (I), unless the  
3           physician or care coordinator of the individual deter-  
4           mines that additional assessments are required due  
5           to sentinel health events or changes in the health  
6           status of the individual that may require changes in  
7           plans of care developed for the individual.

8           “(ii) The development of an initial plan of care,  
9           and subsequent appropriate revisions to that plan of  
10          care.

11          “(iii) The management of, and referral for,  
12          medical and other health services, including multi-  
13          disciplinary care conferences and coordination with  
14          other providers.

15          “(iv) The monitoring and management of medi-  
16          cations.

17          “(v) Patient education and counseling services.

18          “(vi) Family caregiver education and counseling  
19          services.

20          “(vii) Self-management services, including  
21          health education and risk appraisal to identify be-  
22          havioral risk factors through self-assessment.

23          “(viii) Providing access for consultations by  
24          telephone with physicians and other appropriate  
25          health care professionals, including 24-hour avail-

1 ability of such professionals for emergency consulta-  
2 tions.

3 “(ix) Coordination with the principal nonprofes-  
4 sional caregiver in the home.

5 “(x) Managing and facilitating transitions  
6 among health care professionals and across settings  
7 of care, including the following:

8 “(I) Pursuing the treatment option elected  
9 by the individual.

10 “(II) Including any advance directive exe-  
11 cuted by the individual in the medical file of the  
12 individual.

13 “(xi) Activities that facilitate continuity of care  
14 and patient adherence to plans of care.

15 “(xii) Information about, and referral to, hos-  
16 pice services, including patient and family caregiver  
17 education and counseling about hospice, and facili-  
18 tating transition to hospice when elected.

19 “(xiii) Such other medical and health care serv-  
20 ices for which payment would not otherwise be made  
21 under this title as the Secretary determines to be  
22 appropriate for effective care coordination, including  
23 the additional items and services as described in  
24 subparagraph (B).

1           “(B) The Secretary may specify additional ben-  
2           efits for which payment would not otherwise be  
3           made under this title that may be available to eligi-  
4           ble beneficiaries who have made an election under  
5           this section (subject to an assessment by the care  
6           coordinator of an individual beneficiary’s cir-  
7           cumstances and need for such benefits) in order to  
8           encourage the receipt of, or to improve the effective-  
9           ness of, care coordination services.

10          “(2) For purposes of this subsection, the term ‘indi-  
11          vidual with a serious and disabling chronic condition’  
12          means an individual who a care coordinator annually cer-  
13          tifies—

14                 “(A) is unable to perform (without substantial  
15                 assistance from another individual) at least 2 activi-  
16                 ties of daily living (as defined in paragraph (4)) for  
17                 a period of at least 60 days due to a loss of func-  
18                 tional capacity;

19                 “(B) has a level of disability similar to the level  
20                 of disability described in subparagraph (A) (as de-  
21                 termined under regulations promulgated by the Sec-  
22                 retary);

23                 “(C) has a complex medical condition (as de-  
24                 fined by the Secretary) that requires medical man-  
25                 agement and coordination of care; or

1           “(D) requires substantial supervision to protect  
2           such individual from threats to health and safety  
3           due to a severe cognitive impairment (as defined by  
4           the Secretary) or mental condition (as defined by the  
5           Secretary).

6           “(3)(A) For purposes of this subsection, the term  
7           ‘care coordinator’ means an individual or entity that—

8           “(i) is—

9                   “(I) a physician (as defined in subsection  
10                   (r)(1)); or

11                   “(II) a practitioner described in section  
12                   1842(b)(18)(C) or an entity that meets such  
13                   conditions as the Secretary may specify (which  
14                   may include physicians, physician group prac-  
15                   tices, or other health care professionals or enti-  
16                   ties the Secretary may find appropriate) work-  
17                   ing in collaboration with a physician;

18                   “(ii) has entered into a care coordination agree-  
19                   ment with the Secretary; and

20                   “(iii) meets such other criteria as the Secretary  
21                   may establish (which may include experience in the  
22                   provision of care coordination or primary care physi-  
23                   cians’ services).

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

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

5           “(ii) assure that the care coordinator will sub-  
6           mit reports to the Secretary on the functional and  
7           medical status of individuals with a chronic and dis-  
8           abling condition who receive care coordination serv-  
9           ices, expenditures relating to such services, and  
10          health outcomes relating to such services, except  
11          that the Secretary may not require a care coordi-  
12          nator to submit more than 1 such report during a  
13          year; and

14          “(iii) contain such other terms and conditions  
15          as the Secretary may require.

16          “(4) For purposes of this subsection, the term ‘activi-  
17          ties of daily living’ means each of the following:

18                 “(A) Eating.

19                 “(B) Toileting.

20                 “(C) Transferring.

21                 “(D) Bathing.

22                 “(E) Dressing.

23                 “(F) Continence.

1 “(5) Rural health clinics and Federally qualified  
2 health centers shall be eligible sites at which care coordi-  
3 nation and assessment services may be provided.”.

4 (c) PAYMENT AND ELIMINATION OF COINSUR-  
5 ANCE.—

6 (1) IN GENERAL.—Section 1833(a)(1) of the  
7 Social Security Act (42 U.S.C. 1395l(a)(1)) is  
8 amended—

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

10 (B) by inserting before the semicolon at  
11 the end the following: “, and (V) with respect  
12 to care coordination and assessment services de-  
13 scribed in section 1861(s)(2)(W), the amounts  
14 paid shall be 100 percent of the lesser of the  
15 actual charge for the service or the amount de-  
16 termined under the payment basis determined  
17 under section 1848 by the Secretary for such  
18 service”.

19 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-  
20 ULE.—Section 1848(j)(3) of the Social Security Act  
21 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting  
22 “(2)(W),” after “(2)(S),”.

23 (3) ELIMINATION OF COINSURANCE IN OUT-  
24 PATIENT HOSPITAL SETTINGS.—The third sentence  
25 of section 1866(a)(2)(A) of the Social Security Act

1 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-  
2 ing after “1861(s)(10)(A)” the following: “, with re-  
3 spect to care coordination and assessment services  
4 (as defined in section 1861(ww)(1)),”.

5 (d) APPLICATION OF LIMITS ON BILLING.—Section  
6 1842(b)(18)(C) of the Social Security Act (42 U.S.C.  
7 1395u(b)(18)(C)) is amended by adding at the end the  
8 following new clause:

9 “(vii) A care coordinator (as defined in section  
10 1861(ww)(3)) that is not a physician.”.

11 (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-  
12 RALS.—Section 1877(b) of the Social Security Act (42  
13 U.S.C. 1395nn(b)) is amended—

14 (1) by redesignating paragraph (4) as para-  
15 graph (5); and

16 (2) by inserting after paragraph (3) the fol-  
17 lowing new paragraph:

18 “(4) PRIVATE SECTOR PURCHASING AND QUAL-  
19 ITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-  
20 CARE.—In the case of a designated health service, if  
21 the designated health service is—

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

24 “(B) provided by a care coordinator (as  
25 defined in paragraph (3) of such section).”.

1           (f) RULEMAKING.—The Secretary of Health and  
2 Human Services shall define such terms and establish  
3 such procedures as the Secretary determines necessary to  
4 implement the provisions of this section.

5           (g) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to care coordination and assess-  
7 ment services furnished on or after January 1, 2004.

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