

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

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.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Coordinated
5 Community Care Act of 2001”.

1 **SEC. 2. MAKING SOCIAL HEALTH MAINTENANCE ORGANI-**
2 **ZATIONS (S/HMOS) A PERMANENT OPTION AS**
3 **COORDINATED COMMUNITY CARE PLANS**
4 **UNDER THE MEDICARE+CHOICE PROGRAM.**

5 (a) INCLUSION OF COORDINATED COMMUNITY CARE
6 PLANS INTO GROUPING OF MEDICARE+CHOICE COORDI-
7 NATED CARE PLANS.—Section 1851(a)(2)(A) of the So-
8 cial Security Act (42 U.S.C. 1395w–21(a)(2)(A)) is
9 amended by striking “and preferred provider organization
10 plans” and inserting “preferred provider organization
11 plans, and coordinated community care plans (as defined
12 in section 1859(b)(4))”.

13 (b) DEFINITION OF COORDINATED COMMUNITY
14 CARE PLAN.—Section 1859(b) of such Act (42 U.S.C.
15 1395w–29(b)) is amended by adding at the end the fol-
16 lowing new paragraph:

17 “(4) COORDINATED COMMUNITY CARE PLAN.—
18 The term ‘coordinated community care plan’ means
19 a Medicare+Choice plan that (in addition to pro-
20 viding services and otherwise meeting the require-
21 ments of this part) meets the following require-
22 ments:

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

1 “(B) The plan provides as benefits ex-
2 panded care services, as specified in section
3 1852(a)(7), to enrollees who meet the criteria
4 for at-risk enrollees (as defined in paragraph
5 (5)).

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

8 “(D) The plan submits to the Secretary re-
9 ports on the functional status of enrollees as
10 well as on expenditures and utilization of cov-
11 ered expanded care services.

12 “(5) AT-RISK ENROLLEE.—For purposes of de-
13 termining an enrollee’s eligibility to receive expanded
14 care services from a coordinated community care
15 plan, the term ‘at-risk enrollee’ means an enrollee of
16 a coordinated community care plan who has been de-
17 termined by the coordinated community care plan,
18 based on a multidimensional, geriatric assessment,
19 to meet at least one of the following criteria:

20 “(A) The individual needs personal super-
21 vision or hands-on assistance with bathing,
22 dressing, transferring, toileting, eating, or daily
23 mobility assistance inside the home.

1 “(B) The individual needs protection and
2 supervision on a constant basis due to cognitive
3 impairment.

4 “(C) The individual needs daily personal
5 assistance to ensure proper administration and
6 management of prescribed medications or med-
7 ical or nursing procedures.

8 “(D) The individual needs personal assist-
9 ance (at least 3 times a week) to manage incon-
10 tinence problems or ostomy equipment.

11 “(E) The individual needs special ongoing
12 management because the enrollee is frequently
13 disruptive, aggressive, or agitated, or is a dan-
14 ger to self or others.

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

17 “(G) The individual meets such other cri-
18 teria as the Secretary may determine.”.

19 (c) INFORMATION ON BENEFITS.—Section
20 1851(a)(4)(A) of such Act (42 U.S.C. 1395w-
21 21(a)(4)(A)) is amended by adding at the end the fol-
22 lowing new clause:

23 “(ix) In the case of a coordinated
24 community care plan, differences in bene-
25 fits, care coordination services, quality im-

1 provement programs, and other distin-
2 guishing factors compared to other
3 Medicare+Choice plans.”.

4 (d) BASIC AND EXPANDED BENEFITS.—Section
5 1852 of such Act (42 U.S.C. 1395w–22) is amended—

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

8 “(6) BENEFITS OFFERED BY COORDINATED
9 COMMUNITY CARE PLANS.—

10 “(A) IN GENERAL.—In addition to the
11 benefits required under parts A and B, each co-
12 ordinated community care plan shall make
13 available to each enrollee—

14 “(i) chronic illness care services (de-
15 scribed in subparagraph (B)) to manage
16 common geriatric conditions and chronic
17 illness; and

18 “(ii) ancillary services described in
19 subparagraph (C).

20 “(B) CHRONIC ILLNESS CARE SERVICES.—

21 Chronic illness care services under this subpara-
22 graph shall be furnished in accordance with
23 guidelines and protocols adopted by the Sec-
24 retary and by geriatricians, geriatric nurse
25 practitioners, and other providers experienced

1 in chronic illness care. Such services may in-
2 clude geriatric and chronic illness and disability
3 training supplements, consultation with medical
4 specialists, and other services deemed appro-
5 priate by the plans.

6 “(C) ANCILLARY SERVICES.—Ancillary
7 services under this subparagraph—

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

11 “(ii) may also include, at the discre-
12 tion of the plan, such preventive services
13 and other items and services not otherwise
14 covered under part A or B as the plan may
15 specify.

16 “(7) EXPANDED CARE SERVICES FOR AT-RISK
17 ENROLLEES.—

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

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

3 “(i) benefits for home and commu-
4 nity-based services described in subpara-
5 graph (B);

6 “(ii) benefits for supplemental non-
7 acute institutional services described in
8 subparagraph (C) but only in the case of
9 an individual who does not reside in an in-
10 stitutional setting; and

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

13 “(B) HOME AND COMMUNITY-BASED BEN-
14 EFITS.—

15 “(i) IN GENERAL.—The home and
16 community-based services under this sub-
17 paragraph include, subject to clause (ii),
18 personal care, homemakers, medical trans-
19 portation, adult day health, and medication
20 management. Such services may also in-
21 clude routine foot care in the home, home
22 modifications, medical and adaptive equip-
23 ment and supplies, expanded mental health
24 services, personal emergency response sys-

1 tems, home-delivered meals, and nutri-
2 tional assessments and services.

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

8 “(I) for benefits during 2002,
9 shall not be less than \$7,500; or

10 “(II) for benefits during a subse-
11 quent year, shall not be less than the
12 dollar amount specified under this
13 clause for the previous year increased
14 by minimum percentage increase in
15 Medicare+Choice capitation rates
16 provided under section 1853(c)(1)(C)
17 applicable to that subsequent year.

18 “(iii) LIMITS ON COPAYMENTS.—With
19 respect to the benefits under this subpara-
20 graph, a coordinated community care plan
21 may not charge a deductible and may not
22 charge copayments that exceed 25 percent.

23 “(C) SUPPLEMENTAL NON-ACUTE INSTITU-
24 TIONAL SERVICES.—

1 “(i) IN GENERAL.—Benefits for sup-
2 plemental non-acute institutional services
3 under this subparagraph are benefits for
4 institutional care (such as care in an insti-
5 tutional setting, as defined in clause (iv))
6 that is not otherwise covered under part A
7 or part B and that is in aid of returning
8 the enrollee to a community residence and
9 that is provided to an individual who re-
10 sides outside an institutional setting.

11 “(ii) DURATION.—

12 “(I) INITIAL PERIOD OF ELIGI-
13 BILITY.—The benefits under this sub-
14 paragraph shall include at least 14
15 days of supplemental non-acute insti-
16 tutional care.

17 “(II) SUBSEQUENT PERIODS OF
18 ELIGIBILITY.—After receipt of the
19 benefits described in subclause (I),
20 after the at-risk enrollee has resumed
21 residing in a community residence for
22 a continuous period of 60 days, sub-
23 ject to subclause (III), the benefits
24 under this subparagraph shall include

1 at least an additional 14 days of sup-
2 plemental non-acute institutional care.

3 “(III) ANNUAL LIMITATION.—A
4 plan is not required to provide supple-
5 mental non-acute institutional care for
6 more than 30 days of supplemental
7 non-acute institutional care for any
8 enrollee in any calendar year.

9 “(IV) COMMUNITY RESIDENCE.—
10 For purposes of this clause, the term
11 ‘community residence’ means a resi-
12 dence in a community-setting and
13 does not include a residence in any in-
14 stitutional setting.

15 “(iii) LIMITS ON COPAYMENTS.—With
16 respect to the supplemental non-acute in-
17 stitutional services benefit under this sub-
18 paragraph, the coordinated community
19 care plan may not charge a deductible and
20 may not charge copayments that exceed 25
21 percent.

22 “(iv) INSTITUTIONAL SETTING.—For
23 purposes of this paragraph, the term ‘insti-
24 tutional setting’ includes a nursing facility,

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

3 “(D) END-OF-LIFE CARE.—End-of-life and
4 palliative care services under this subparagraph
5 shall not be limited to the last 6 months of life,
6 shall cover a broader range of life-limiting con-
7 ditions than traditional hospice care, and shall
8 include support of family caregivers.”; and

9 (2) by adding at the end the following new sub-
10 section:

11 “(m) CARE COORDINATION.—Coordinated commu-
12 nity care plans shall adopt a care coordination program
13 for serving members. This program shall include geriatric-
14 focused assessment and care planning that meet at least
15 the following requirements:

16 “(1) POPULATION SCREENING.—The coordi-
17 nated community care plan shall screen each new
18 enrollee upon enrollment and annually thereafter
19 through a self-report health status form with a
20 standardized set of core items designed to identify
21 enrollees who may be at risk due to medical, psycho-
22 logical, behavioral, environmental, or functional con-
23 ditions.

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

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

7 “(3) COMPREHENSIVE ASSESSMENT AND PLAN-
8 NING.—In the case of an enrollee identified as an at-
9 risk enrollee, a care coordinator in the coordinated
10 community care plan shall contact the enrollee to de-
11 termine the enrollee’s need for a comprehensive as-
12 sessment to determine the enrollee’s needs, pref-
13 erences, and eligibility for expanded care benefits.
14 Such an assessment shall be conducted in the enroll-
15 ee’s home and other settings, as appropriate, using
16 flexible, multidimensional geriatric approaches that
17 incorporate medical, functional, psychological, and
18 environmental dimensions. All at-risk enrollees shall
19 be assigned a care coordinator who will develop an
20 expanded care plan based on the multidimensional
21 assessment, information on medical status and care,
22 and member preferences. The coordinated commu-
23 nity care plan shall assure that at-risk enrollees be
24 referred in a timely manner to the appropriate pro-

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

3 “(4) INTEGRATION OF CARE.—Procedures shall
4 be established among such care coordinators and
5 acute and expanded care providers in such plans to
6 ensure timely sharing of clinical information, assign-
7 ment of responsibility, and coordination and integra-
8 tion of services under the expanded care plan across
9 all providers and settings in a manner that meets
10 the special needs of geriatric and chronically ill or
11 impaired individuals.”.

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

15 “(E) COORDINATED COMMUNITY CARE
16 PLANS.—In addition in the case of a coordi-
17 nated community care plan, the quality assur-
18 ance program shall employ systems to ensure
19 the quality of covered expanded care and chron-
20 ic illness care services. The Secretary shall es-
21 tablish appropriate outcome measures for as-
22 sessing the quality of care provided to frail el-
23 derly and at-risk enrollees with chronic condi-
24 tions in such plans. Such outcome indicators

1 shall measure plans' and providers' effective-
2 ness in—

3 “(i) integrating the delivery of acute
4 care and expanded care;

5 “(ii) meeting identified expanded care
6 needs;

7 “(iii) preventing, delaying, or mini-
8 mizing disability progression; and

9 “(iv) preventing or delaying institu-
10 tionalization.”.

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

14 “(j) COORDINATED COMMUNITY CARE PLANS.—Not-
15 withstanding the previous provisions of this section, each
16 coordinated community care plans shall be paid under this
17 section as follows:

18 “(1) IN GENERAL.—Except as provided in para-
19 graph (2)—

20 “(A) CURRENT SOCIAL HMOS.—In the case
21 of a coordinated community care plan that con-
22 tracted with the Secretary to furnish services as
23 a social HMO during 2001 and that continues
24 to contract with the Secretary following the ef-
25 fective date of this subsection, payment shall be

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

3 “(B) OTHER PLANS.—In the case of a co-
4 ordinated community care plan not described in
5 subparagraph (A), before the adoption and im-
6 plementation of a new payment methodology for
7 coordinated community care plans under para-
8 graph (2), the Secretary shall have the discre-
9 tion to select one of the 2 methodologies for
10 risk adjustment factors and formula that may
11 be applied under subparagraph (A) to pay any
12 Medicare+Choice coordinated care plan that is
13 certified as a coordinated community care plan.

14 “(2) NEW PAYMENT METHODOLOGY.—The Sec-
15 retary shall develop a new payment methodology to
16 pay coordinated community care plans. In developing
17 this new payment methodology, the Secretary shall
18 be guided by the following 3 factors:

19 “(A) Recognizing that impairment-related
20 costs are not adequately accounted for in the
21 individual diagnostic and demographic factors
22 used to adjust payments for other
23 Medicare+Choice plans, a functional status fac-
24 tor or factors or other factors equally sensitive
25 to costs associated with disability, frailty, and

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

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

16 “(C) The Secretary shall assure that the
17 payment methodology will not change because a
18 coordinated community care plan has a contract
19 with a State under title XIX to serve individ-
20 uals dually eligible under this title and that
21 title.

22 “(3) TRANSITION.—If the payment method-
23 ology developed by the Secretary under paragraph
24 (2) results in a reduction of payment to a coordi-
25 nated community care plan that is receiving pay-

1 ment under a method described in paragraph (1),
2 the Secretary shall establish a 4-year transition pe-
3 riod during which the new payment methodology is
4 phased in. During the first year of the transition,
5 payment will be based on a blend weighted $\frac{1}{4}$ of the
6 new payment methodology under paragraph (2) and
7 $\frac{3}{4}$ of the payment methodology under paragraph
8 (1). During each of the second and third years, pay-
9 ment will be based on a blend weighted $\frac{1}{2}$ and $\frac{3}{4}$,
10 respectively, of the new payment methodology under
11 paragraph (2) and $\frac{1}{2}$ and $\frac{1}{4}$, respectively, based on
12 the payment methodology under paragraph (1). The
13 Secretary shall fully implement the new payment
14 methodology during the fourth year.

15 “(4) COMMENT.—The Secretary shall submit
16 the new payment methodology for coordinated com-
17 munity care plans to public comment as part of the
18 advance notice of methodological changes under sec-
19 tion 1853(b)(2).”.

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

23 “(F) SPECIAL RULES FOR COORDINATED
24 COMMUNITY CARE PLANS.—

1 “(i) Each coordinated community care
2 plan shall include as additional benefits
3 those services described in paragraphs (6)
4 and (7) of section 1852(a) unless inclusion
5 of the additional benefits results in the ac-
6 tual value of the benefits exceeding the
7 average of the capitation payments made
8 to the coordinated community care plan. If
9 so, the coordinated community care plan
10 may treat the excess as a supplemental
11 benefit (as defined in section 1852(a)(3)),
12 and charge a premium for the actuarial
13 value of the excess costs.

14 “(ii) Nothing in this part shall be con-
15 strued to preclude a coordinated commu-
16 nity care plan from furnishing the services
17 specified in section 1852(a)(7) only to at-
18 risk enrollees (as defined in section
19 1859(b)(5)).”.

20 (g) DISCRETION TO WAIVE REQUIREMENTS.—Sec-
21 tion 1856(b) of such Act (42 U.S.C. 1395w-26(b)) is
22 amended by adding at the end the following new para-
23 graph:

24 “(4) ADAPTATION TO COORDINATED COMMU-
25 NITY CARE PLANS.—In establishing standards under

1 this section, the Secretary shall adapt such stand-
2 ards as they apply to coordinated community care
3 plans to appropriately account for their unique char-
4 acteristics as reflected in the composition of enroll-
5 ment and the care coordination and expanded ben-
6 efit requirements under this part.”.

7 (h) EFFECTIVE DATE; TRANSITION.—

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

11 (2) TRANSITION.—

12 (A) IN GENERAL.—Upon the enactment of
13 this section, the Secretary of Health and
14 Human Services shall proceed in an expedited
15 manner to develop and promulgate the nec-
16 essary rules and the payment methodology re-
17 quired by the amendments made by this sec-
18 tion.

19 (B) APPLICATION OF REQUIREMENTS.—

20 Except as provided in paragraph (3), the Sec-
21 retary of Health and Human Services may not
22 certify a Medicare+Choice organization as
23 meeting the requirements applicable to coordi-
24 nated community care plans under part C of
25 title XVIII of the Social Security Act until the

1 adoption of final regulations implementing the
2 statutory requirements applicable to coordi-
3 nated community care plans under such part.

4 (3) DEEMED TREATMENT.—

5 (A) CURRENT S/HMOS.—Any
6 Medicare+Choice organization that is operating
7 as of the date of the enactment of this Act
8 under demonstration authority as a Social
9 HMO (S/HMO I or S/HMO II or a combination
10 thereof) shall be deemed to meet the require-
11 ments applicable to coordinated community care
12 plans under part C of title XVIII of the Social
13 Security Act from the effective date specified in
14 paragraph (1) through 24 months following the
15 date the Secretary publishes final regulations
16 establishing standards for coordinated commu-
17 nity care plans under the amendments made by
18 this section.

19 (B) S/HMOS WITH PLANNING GRANTS.—

20 In the case of an entity that received a planning
21 grant in 1998 under the 1997 Grants Program
22 for Reforming Service Delivery for Dual Eligi-
23 ble Beneficiaries to develop a Second Genera-
24 tion Social HMO Demonstration program, if
25 the Secretary determines that the program de-

1 veloped under such a grant would qualify to op-
2 erate as a demonstration authority as a Social
3 HMO (S/HMO I or S/HMO II or a combination
4 thereof), the Secretary may treat the entity
5 with respect to such program as a Social HMO
6 for purposes of applying subparagraph, effective
7 on a date specified by the Secretary.

8 (4) IMMEDIATE REMOVAL OF LIMITATION ON
9 NUMBER OF MEMBERS PER SITE UNDER DEM-
10 ONSTRATION PROJECT.—Section 13567(c) of the
11 Omnibus Budget Reconciliation Act of 1993, as
12 amended by sections 4014(b) of the Balanced Budg-
13 et Act of 1997 and by section 531(c) of the Medi-
14 care, Medicaid, and SCHIP Balanced Budget Re-
15 finement Act of 1999 (113 1501A–388), is
16 amended—

17 (A) in the heading, by striking “AGGRE-
18 GATE” and inserting “NO”; and

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

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

1 ber of coordinated community care plans under part
2 C of title XVIII of the Social Security Act (in addi-
3 tion to the plans referred to in paragraph (3)):

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

6 (B) In the second such year, 15 coordi-
7 nated community care plans.

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

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

12 (i) ADVISORY COMMITTEE.—

13 (1) ESTABLISHMENT.—The Secretary of Health
14 and Human Services shall establish a National Advi-
15 sory Committee on Social HMO Replication to assist
16 Medicare+Choice plans, health care providers, and
17 other appropriate organizations in the design, imple-
18 mentation, and ongoing evaluation of coordinated
19 community care plans under the amendments made
20 by this section.

21 (2) MEMBERSHIP.—Membership on the com-
22 mittee shall include representation from the fol-
23 lowing:

24 (A) Existing Social HMO I and II sites.

25 (B) Social HMO II planning grant sites.

1 (C) Providers and professionals with exper-
2 tise in geriatric medicine, chronic illness care
3 and home and community-based service pro-
4 grams.

5 (D) Representatives from the Federal and
6 State governments with oversight responsibil-
7 ities for programs serving the elderly and dis-
8 abled.

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

13 (F) Such other representatives as the Sec-
14 retary may designate.

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